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F 000	INITIAL COMMENTS	F 000		

Amended 7/16/12

The following deficiencies are the result of the recertification and state licensure survey done in conjunction with facility reported incident 38958-I and complaint 39071-C with allegations substantiated..

kw CK 7-17-12

See Code of Federal Regulation (42 CFR) Part 483, Subpart B - C.

Correction Date 7/31/12.

F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156	

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to ensure the staff was trained to provide information to residents and/or their family members so they would be informed as to

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how to enact the opportunity to have their skilled stay reviewed by the fiscal intermediary when the resident moved from skilled care to long term care based on the facility's decision. Concerns noted for 24 records reviewed. The facility census included 59 residents.

Findings included:

1. A review of records on 5/23/12 revealed the facility discharged 20 residents from skilled care from 10/3/11-3/2/12 issuing a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, standard claim appeal) and the same as a Denial Letter or CMS Form 10055 used to inform beneficiaries or their responsible parties or Power of Attorney of potential for liability of non-covered services and of the right to file a standard claim. Six forms were signed by the residents themselves with the remaining signed by the responsible parties or resident's Power of Attorney (POA). Twenty out of twenty forms did not have either Option A or "Yes" or Option B or "No" checked. Option A gives the resident or responsible party the right to have the services continued and the bill submitted to Medicare for a decision. Option B gives the resident or responsible party the right to not receive services and not submit a claim to Medicare for a review.

From 8/9/11 to 9/15/11 the facility discharged eleven residents from a skilled level of care and provided the Notice of Medicare Provider Non Coverage or "generic letter" Form 0938-0953. Six were signed by residents and four were signed by the responsible party and one was not signed or dated. Four of the residents currently reside in the facility.

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Staff J, interviewed on 5/23/12 at 10 a.m. stated she was hired 8/2011 for the social service position at the facility. She stated the forms she gave to the residents or responsible parties were not filled out because she didn't educate them to the options. She stated she does the letters but the decision to come off skilled care was either Physical therapy or the Director of nursing's decision. She stated she wasn't given training on the forms until 2/12 when the corporate nurse consultant explained demand billing to her.

By failing to provide training to Staff J to ensure she understood the intent of the letters, the facility did not ensure the resident's rights to request a standard review claim appeal or an expedited claim appeal (done within 72 hours) for financial liability.

F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) — F 157

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in

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§483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility staff failed to notify the physician for 1 of 15 sampled residents related to a seizure lasting one hour (Resident #5). The facility reported a census of 59 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment Tool dated 02/10/2012 identified Resident #5 with diagnoses of traumatic brain injury and seizure disorder.

The care plan dated 04/17/2008 through 05/22/2012 identified Resident #5 with a seizure disorder and an approach to use a specific seizure protocol per the doctor's orders.

Nurse's notes dated 5/09/12 at 6:30 p.m. documented the CNA's (certified nurse's aide)

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reported the resident having seizure activity at the dining room table. The nurse gave PRN (as needed) medication of Ativan (antianxiety 2 milligram(mg) /milliliter) 0.5 milliliters for 1 mg given. According to the Physician's orders this was a liquid to be given through the gastrostomy tube (tube that enters the stomach through the abdomen). The resident sat in the lobby with nurse his/her side. The note indicated the staff would continue to monitor.

The nurse's notes dated 05/09/12 at 7:00 p.m. revealed seizure activity progressed into a grand mal seizure. The CNA assisted the nurse to put resident to bed. Valium (medication used for treatment of seizures) 10 milligrams (mg) given rectally. The staff positioned the resident to a side lying position with seizure precautions in place. The resident was unable to speak, or to look at nurse when spoken to. A CNA was at residents's side. The staff would continue to monitor.

Nurse's notes dated 5/09/12 at 7:15 p.m. revealed the seizure activity continued. The resident able to make eye contact when spoken to, but remained unable to speak. Seizure precautions remained in place. The nurse was at the bedside. The staff would continue to monitor.

Nurse's notes dated 5/09/12 at 7:30 p.m. seizure activity stopped. Resident able to speak when spoken to. Vital signs: temperature 98.1 degrees Fahrenheit, pulse 100 beats per minute, respirations 18 per minute, blood pressure 132/78, and oxygen saturation at 96 percent on room air. Seizure precaution continue to be in place. Will continue to monitor.

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The record lacked documentation of physician notification through the prolonged seizure.

During an interview on 05/23/12 at 8:45 a.m. Staff I, Assistant Director of Nursing (ADON), reported the medical record should have the seizure protocol and that physician notification is expected for a seizure. Staff I confirmed the medical record contained no documentation of physician notification for the seizure on 05/09/12.

F 246 SS=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES — F 246

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and resident interview, the facility failed to complete routine treatments during waking hours for 3 of 15 residents reviewed (Resident #8, #13, #14.) The facility reported a census of 59 residents.

Findings include:

1. The MDS dated 3/16/12 documented Resident #13 had diagnoses including multiple sclerosis, and anxiety, and neurogenic bladder. The MDS documented the resident as fully dependent on

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staff for transfers and did not walk. The MDS documented the resident had a suprapubic catheter. The MDS documented the resident scored a 5 out of 15 on the brief interview for mental status indicating poor memory and poor recall.

The physician instructed staff to change the catheter monthly.

The nurses notes dated 3/28/12 at 11:00 p.m. staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 8/29/12 at 4:45 a.m. staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 10/29/12 at 3:30 a.m. staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The care plan directed staff to change the catheter per orders. It did not reveal that the resident benefited in anyway from having the catheter change done during the night hours.

A reasonable person would prefer not to have a catheter change performed during times of sleep.

2. The MDS dated 4/26/12 documented Resident

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#14 had diagnoses including neurogenic bladder and multiple sclerosis. The MDS documented the resident as fully dependent on staff for all cares and did not ambulate. The MDS documented the resident had a catheter. The MDS documented the resident had short and long term memory impairment as well as moderately impaired decision making abilities.

The physician instructed staff to change the catheter twice a month.

The nurse's notes dated 9/29/11 at 12:00 a.m. documented staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 11/16/11 at 1:30 a.m. documented staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 12/22/11 at 5:00 a.m. documented staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 2/29/12 at 1:00 a.m. documented staff performed the catheter change. The documentation lacked evidence of a problem with the catheter making the change necessary at time of day.

The nurse's notes dated 3/30/12 at 12:30 a.m. documented staff performed the catheter change.

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The entry indicated the catheter change was due to the monthly catheter change.

During an interview on 5/23/12 at 6:19 p.m. Staff I, licensed practical nurse, stated all routine treatments and catheter changes will be done during the day shift starting 5/1/12.

3. A quarterly MDS (Minimum Data Set Assessment) dated 3/29/12 identified Resident #8 with the following diagnoses of Alzheimer's Disease and depression. The MDS coded the resident with both memory impairment and severely impaired cognitive function related to daily decision making skills. The MDS coded the resident as totally dependent upon staff for bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Toileting did not occur during the assessment look back period. The MDS coded the resident with no functional limitation in range of motion. The MDS identified the resident as always incontinent of bowel and bladder function. The MDS coded the resident without any skin irritation or skin breakdown and identified the following interventions in place: pressure reduction device for chair, pressure reduction mattress for bed, nutrition and hydration interventions, application of ointments/medications other than to feet, and application of dressing to the feet. The MDS coded the resident received passive range of motion 1 day during the assessment look back period.

The resident care plan reviewed on 4/11/12 identified the resident as totally dependent upon the staff for all ADL's (Activities of daily living). The care plan interventions directed staff to provide step by step instructions when providing

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cares and place in a restorative nursing program for exercise. The care plan also identified a history of skin breakdown related to immobility, incontinency and progression of Alzheimer's Disease. The staff used the Hoyer lift with 2 assist for all transfers.

An observation made on 5/16/12 at 5:50 a.m. revealed Staff C, CNA (Certified Nursing Assistant), donned gloves to perform incontinence care for Resident #8. Staff C cleansed the perineal area and rolled the resident onto the left hip to perform perineal cares to the rectal area and buttocks. Staff C pulled somewhat forcibly on the residents hips while attempting to turn and reposition the dependent resident alone. Staff C pulled again on the resident's hips while rolling and repositioning onto the left hip to cleanse the right hip, upper thigh, and buttock regions. Staff C stated during the procedure that she really needed to have another person assisting her to perform perineal care to the resident. The manner in which the CNA pulled and tugged on the resident's hips placed the resident at potential risk for hip dislocation, bone fractures, and skin friction abrasions, bruising, and skin tears, in addition to causing the resident needless pain and anxiety due to choosing to perform this task alone.

Observations made on 5/16/12 at 6:35 a.m. revealed Staff D, CNA, and Staff E, CNA transferred the resident from the bed by Hoyer lift into the recliner chair. The resident immediately leaned to the right side while seated in the recliner chair. Staff D and Staff E did not attempt to reposition the resident into a more comfortable position with proper body alignment. Additional

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F 246	Continued From page 12 observations made at 7:45 a.m., 8:30 a.m., 9:30 a.m., 11:50 a.m., and 12:55 p.m., revealed the resident leaning to the right in the recliner chair without use of positioning pillows or supportive devices to assist the resident to sit more comfortably in the chair.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and observation, the facility failed to ensure the activities offered to the residents establish resident centered activity goals on the care plan. Concern noted for 6 of 15 residents reviewed. Concerns noted for Resident #1, #4, #6, #8, #10, and #14 . The facility reported a census of 59 residents. Findings include: 1. The MDS assessment dated 4/5/12 documented Resident #10 had diagnoses including Alzheimer's disease, anxiety, and a psychotic disorder. The MDS documented the resident required extensive assistance for transfers and required moderate assistance for walking. The resident has a Brief Interview for Mental Status (BIMS) score of 7 indicating cognitive deficits.	F 248		

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The care plan dated 4/18/12 documented the resident sat the lobby while others participated in activities. The care plan failed to list a resident centered goal except for the activity staff continuing to ask the resident to participate in the lobby activities. An approach on the care plan was for the resident to receive 1:1 activities when not coming to at activities or when he/she was restless.

The activity assessment dated 4/16/12 documented the resident attended six or more activities a week. With the poor vision and poor hearing items both checked, large group activities may not benefit the resident.

The daily record of resident participation for March 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily record documented staff provided one to ones seven times in the month but did not document the one to one activity staff provided.

The daily record of resident participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily record documented staff provided one to one activities nine times in the month but did not document the one to one activity staff provided.

The daily record of resident participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily recorded documented one to one activities four times but did not document the

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one to one activity staff provided.

During observation on 5/21/12 at 9:33 a.m. the resident sat in the lobby with eyes closed. Activity staff directed a group exercise nearby.

On 5/23/12 at 2:21 p.m. activity staff conducted a group activity bingo in the dining room. The resident sat in a recliner in the lobby not participating.

2. The MDS dated 4/26/12 documented Resident #14 had diagnoses including neurogenic bladder and multiple sclerosis. The MDS documented the resident as fully dependent on staff for all cares and did not ambulate. Resident #14 had short and long term memory loss and had severe cognitive deficits.

The activity assessment dated 5/8/12 documented the resident participated in three to five activities and received one to one visits. The activity assessment indicated the resident enjoyed large group activities but was unable to make needs known, was dependent on others for wheelchair transportation and was forgetful and needed reminders.

The care plan dated 5/9/12 listed an activity goal of participation in large group activities 50% of the time.

The daily record of resident participation for March 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily record documented staff provided one to ones nine times in the

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month but did not document the one to one activity staff provided.

The daily record of resident participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily record documented staff provided one to one activities eleven times in the month but did not document the one to one activity staff provided.

The daily record of resident participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended. The daily recorded documented one to one activities four times but did not document the one to one activity staff provided.

During observation on 5/23/12 at 2:21 p.m. activity staff conducted a group activity bingo. The resident remained in the room in bed with eyes open.

During an interview on 5/22/12 at 1:40 p.m. Staff L, activity director, stated sensory stimulation consists of music, reading, and applying lotion and done on a one to one basis. Staff L stated she did one to ones twice weekly but failed to document the activity provided.

During an interview on 5/23/12 at 1:13 p.m. Staff L stated she had activity director education but had training in care plans. Staff L stated she did not have knowledge that the resident needed a resident centered goal and to document the specific activity the resident attended.

3. The Minimum Data Set (MDS) Assessment Tool dated 03/09/12 identified Resident #1 with

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diagnoses of cerebral palsy and a seizure disorder.

The care plan dated 01/15/2010 through 06/19/2012 identified the resident as unable to participate in activities due to profound MR (mental retardation). The goal documented the resident will respond to sensory stimulation by making eye contact. The care plan failed specify what staff were to do to provide the sensory stimulation, or how many minutes the staff would provide the sensory stimulation and the resident's response to the sensory stimulation..

The sensory stimulation record for months March, April, and May 2012 identified activities performed: read to him/her, sang, and looked at pictures. The activity documentation lacked information as to what type of items read to the resident, types of music, types of pictures, length of time spent, and resident's response. The document revealed the resident's response as (good visit) each time.

With the resident being unable to inform staff what was soothing or created comfort or enjoyment, other staff would be unable to provide things that interested Resident #1.

4. The Minimum Data Set (MDS) Assessment Tool dated 03/02/12 identified Resident #6 with diagnoses of cerebral palsy, dementia, and seizure disorder.

The care plan dated 06/10/2010 through 06/12/2012 identified the resident as present for lobby activity and not always a direct participant.

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The goal documented the resident will demonstrate participation and enjoyment in activity as evidenced by : jumping up and down or making sounds. The approach identified staff to provide sensory stimulation for him/her and assist as needed to participate in sensory stimulation. The care plan failed specify what staff were to do to provide the sensory stimulation, or how many minutes the staff would provide the sensory stimulation and the resident's response to the sensory stimulation.

The sensory stimulation record for months March and May 2012 identified activities performed: read to him/her, sang, and looked at pictures. The activity lacked actual description of items read to the resident, types of music, types of pictures, length of time spent.

The staff documented the resident's reaction to the sensory stimulation included some eye contact and no verbal, when the care plan indicated jumping up and down or making sounds demonstrated participation and enjoyment.

5. A quarterly MDS dated 3/29/12 identified Resident #4 with the following diagnoses of diabetes, Alzheimer's Dementia, and anxiety disorder. The resident scored 3/15 on the Brief Interview for mental status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident required extensive staff assist with bed mobility, dressing, personal hygiene, and bathing. The MDS identified the resident required total staff assist with transfers and toilet use, and limited staff assist for eating. The MDS coded

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the resident as occasionally incontinent of bowel and frequently incontinent of bladder. The MDS coded the resident with functional limitation in range of motion on one side for the upper extremities and both sides for the lower extremities. The MDS coded the resident with no falls since the prior assessment period. The MDS coded the resident received passive range of motion on 2 of the 7 days during the assessment look-back period.

The resident care plan reviewed on 4/11/12 identified a problem due to cognitive impairment and required assistance to and from activities. The care plan interventions directed staff invite and encourage the resident to participate in activity, explain to resident what the activity is and where it is located, assist the resident as needed to participate in the activity, ask nursing to assist the resident to activities as needed, and continue to do sensory stimulation with the resident. Neither the care plan or the activity assessment identified what sensory stimulation included.

Observations made on 5/16/12 at 9:30 a.m., 10:45 a.m., 11:50 a.m., 12:58 p.m., and 2:00 p.m. revealed the resident out in the main lobby area seated in either the wheelchair or the recliner chair apparently asleep with no activity participation or interaction noted either in a group setting or in a 1 to 1 interaction. During these observations, the resident received no additional sensory stimulation activities.

The activity quarterly assessment completed on 4/9/12 indicated the resident attended an average of 6 or more activities per week, participated as both an active and inactive participant, and

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continued to receive sensory stimulation for psychosocial needs. The activity progress note dated 4/9/12 documented the resident participates in church, music programs, afternoon delight, bingo, and activities does sensory stimulus with the resident. The note continued to document the resident watches television in the lobby.

6. A quarterly MDS (Minimum Data Set Assessment Tool) dated 3/29/12 identified Resident #8 with the following diagnoses of Alzheimer's Disease and depression. The MDS coded the resident with both memory impairment and severely impaired cognitive function related to daily decision making skills. The MDS coded the resident as totally dependent upon staff for bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Toileting did not occur during the assessment look back period. The MDS coded the resident with no functional limitation in range of motion. The MDS identified the resident as always incontinent of bowel and bladder function. The MDS coded the resident without any skin irritation or skin breakdown and identified the following interventions in place: pressure reduction device for chair, pressure reduction mattress for bed, nutrition and hydration interventions, application of ointments/medications other than to feet, and application of dressing to the feet. The MDS coded the resident received Passive range of motion 1 day during the assessment look back period.

The resident care plan reviewed on 4/11/12 identified as a problem low functioning due to cognitive decline requiring sensory stimulation to

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F 248	Continued From page 20 help maintain present level of function. The care plan interventions directed the staff to do sensory stimulation type activity with the resident, encourage the resident to participate in sensory stimulation, and assist the resident as needed for participation in the activity offered. The activity quarterly assessment completed on 4/9/12 identified the resident as unable to participate in group activities but did not check one to one visits. The assessment also did not indicate the resident received sensory stimulation activities. The activity progress note dated 4/9/12 documented the resident's family visited daily, activities provided sensory stimulation with the resident, and the television and radio played throughout out the day. Observations made on 5/16/12 at 7:45 a.m., 8:30 a.m., 9:30 a.m., 10:45 a.m., 11:50 a.m., 12:55 p.m., and 1:45 p.m. revealed the resident asleep either in the recliner chair in the resident's room or resting in bed with no active staff interaction except during mealtime as the staff fed the resident with the room radio on.	F 248		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced	F 252		

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by:
Based on observation and record review, the facility failed to maintain resident equipment in good condition, free of rips and tears, to ensure safety and comfort and maintain a sanitizable surface for 1 of 15 residents observed (Resident #6). The facility reported a census of 59 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment assessment dated 03/02/12 identified Resident #6 with diagnoses of cerebral palsy, dementia, and seizure disorder.

The care plan dated 11/20/2008 through 06/12/2012 identified Resident #6 with diagnoses of cerebral palsy and seizure disorder. The care plan documented the resident used a special wheelchair with safety devices of trunk restraint (shoulder straps), seat belt, and straps over shoes.

Observation on 05/16/12 at 7:13 a.m. noted the resident up in his/her wheelchair, noted chest/shoulder harness, seatbelt, and foot/shoe straps in place. Observation of the chest/shoulder harness revealed multiple horizontal rips and tears with areas of vinyl missing and also areas with rolled up sharp edges. The harness vinyl material remained in this condition the entire length of the survey. The condition of the harness remained unsanitizable.

F 279 SS=E — 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

A facility must use the results of the assessment

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to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, and staff interview, the facility failed to create and update the care plan for 8 of 15 residents reviewed; Residents #1, #2, #5 #9. The facility reported a census of 59 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 4/26/12 documented diagnoses for Resident #9 including hypertension, depression, and a history of breast cancer. The MDS documented the resident had inattention, feeling depressed or hopeless, had a poor appetite, and

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thoughts about wanting to dead, or wanting to hurt themselves.

The nurse's notes dated 1/27/12 at 4:45 a.m. documented the resident stated they had lived long enough and too tired to live any longer.

The nurse's notes dated 1/10/12 at 12:00 p.m. documented the resident showed signs and symptoms of depression as evidenced by poor appetite, lack of participation in activities, and making comments about wanting to die. The documentation included the resident was not currently taking an antidepressant.

On 01/11/12 the physician prescribed an anti-depressant.

The social service progress notes dated 1/30/12 documented contact with the resident's spouse, however, the note failed to address the resident's psychosocial needs.

The social service progress notes dated 5/1/12 documented the resident felt old and ready to die. The resident denied any feelings of wanting to self harm.

During an interview on 5/23/12 at 2:00 p.m. Staff J, Social Service staff, stated she visited with the resident regarding the comments about death. Staff J stated a resident who lived down the hall from the resident passed away and this triggered the resident to make comments about death. Staff J visited with the resident's daughter who stated the resident gets upset when she hears about someone dying and will make comments

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about death.

The Social Service progress notes did not address Staff J discussed with the resident's daughter the resident's comments regarding death.

The care plan dated 5/9/12 listed the resident will make comments related to having lived long enough, having a history of being lethargic at meals, and weakness, increased fatigue and depression. The care plan failed to provide interventions to monitor the resident's mood or to provide support to the resident at times a death occurs of someone she knows.

2. The Minimum Data Set (MDS) Assessment Tool dated 03/09/12 identified Resident #1 with diagnoses of cerebral palsy and a seizure disorder. The MDS identified the resident required total dependence of two staff for toileting, bed mobility, and transfers. The MDS identified the resident with impairment of functional limitation in range of motion for both side of the lower extremities (hip, knee, ankle, foot).

The care plan identified dependency on staff due to history of cerebral; palsy, profound mental retardation and contracted and crossed scissoring of legs and spastic hemiplegia.

According to the incident summary provided to the Department of Inspections and appeals, on 4/29/12 during incontinence cares of large amount of bowel movement two certified nurse aides (CNA's) assisted Resident #1 when the

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CNA's heard a "pop" and noticed the leg was disfigured. One CNA was cleaning and the other was holding up the resident's leg. The report noted the resident resisted cares.

Observation on 05/16/2012 at 8:04 a.m. revealed Resident #1 in bed and observed bilateral lower leg extremities contracted in a scissor like position, left leg over the right crossed at knees.

The care plan identified Resident #1 with limited physical mobility due to leg contractions (crossed). The care plan identified and problem for needing total assistance with ADL's but failed to care plan the chronic dislocation of the left hip and an alternate approach for cleaning extensive loose bowel movement.

When Resident #1 returned from the hospital the care plan was not amended to include special interventions for his incontinency care.

3. The Minimum Data Set (MDS) Assessment dated 05/10/2012 identified Resident #2 with diagnoses of coronary artery disease, hypertension, end stage renal disease, chronic obstructive pulmonary disease. The MDS identified the resident received special treatment of oxygen therapy and dialysis treatment.

The initial care plan dated 05/03/12 lacked a problem of the resident having end stage renal disease and receiving hemodialysis treatments three times a week, on Monday, Wednesday and Friday. The resident had a left arm dialysis shunt not identified. The care plan did not identify emergency management or complications of

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F 279	Continued From page 26 bleeding/hemorrhaging, or monitoring for infections. The permanent care plan developed on 5/15/12 also failed to have a problem identified covering goals and interventions for end stage renal disease and receiving hemodialysis treatments. 4.. The Minimum Data Set (MDS) Assessment dated 02/10/2012 identified Resident #5 with diagnoses of traumatic brain injury and seizure disorder. The care plan dated 04/17/2008 through 05/22/2012 identified Resident #5 with a seizure disorder and an approach to use a specific seizure protocol per the doctor's orders. The care plan lacked documentation as to what the specific actions the staff were to provided related to the seizure protocol with the identified approaches. During an interview on 05/23/12 at 8:45 a.m. Staff I, Assistant Director of Nursing (ADON), reported the medical record should have the seizure protocol . On 5/23/12 at 9:00 a.m. Staff R, Licensed Practical Nurse, stated the seizure protocol could not be located.	F 279		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, and staff interview, the facility failed to follow professional standards regarding medication administration for 4 of 15 residents reviewed (Resident #4, #11, and #25) and orders for discharge for two residents (Resident #2 & #21). The facility reported a census of 59 residents.

Findings include:

1. The MDS dated 5/3/12 documented Resident #11 had diagnoses including hypertension and peripheral vascular disease. The MDS documented the resident took an anticoagulant medication (Coumadin) daily.

Review of the Medication Administration Record (MAR) for May 2012 documented the resident received Coumadin 2 milligrams (mg) of Coumadin every day at bedtime.

On 5/9/12 the physician ordered Coumadin 2.5 mg daily.

A coagulation time laboratory test (PT/INR) dated 5/16/12 documented the clotting time as 11.0 when the range is 8.2-13.0. The INR (International Normalized Ratio) was 1.04 to a range of 1.0-3.9. The therapeutic INR range for a patient on Coumadin is usually 2.0-3.0 The facility sent a facsimile to the physician making her aware of the values. The facility staff reported the resident was on 2 mg of Coumadin. The facility staff had not changed the order to Coumadin 2.5 mg as ordered on 5/9/12.

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The physician increased the Coumadin to 4 mg a day.

2. A quarterly MDS (Minimum Data Set Assessment Tool) dated 3/29/12 identified Resident #4 with the following diagnoses of diabetes, Alzheimer's Dementia, and anxiety disorder. The resident scored 3/15 on the Brief Interview for mental status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident required extensive staff assist with bed mobility, dressing, personal hygiene, and bathing. The MDS identified the resident required total staff assist with transfers and toilet use, and limited staff assist for eating. The MDS coded the resident as occasionally incontinent of bowel and frequently incontinent of bladder. The MDS coded the resident with functional limitation in range of motion on one side for the upper extremities and both sides for the lower extremities. The MDS coded the resident with no falls since the prior assessment period. The MDS coded the resident received passive range of motion on 2 of the 7 days during the assessment look-back period.

A physician order dated 4/28/12 directed staff to obtain a urine for analysis and culture and sensitivity if indicated. On 4/29/12 the physician ordered Cipro (antibiotic used for the treatment of a urinary tract infection) 500 mg (Milligrams) twice a day for 5 days.

The April MAR (Medication Administration Record) indicated the Cipro began on 4/29/12 with 2 doses given on 4/29/12, 4/30/12, 5/1/12,

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5/2/12, 5/3/12, and 5/4/12 at breakfast. The nursing note documentation on 5/6/12 at 11:00 a.m. indicated the antibiotic complete for the treatment of the urinary tract infection. The antibiotic end date according to physician order ended after the bedtime dose given on 5/3/12.

3. The Minimum Data Set (MDS) Assessment dated 05/10/2012 identified Resident #2 with diagnoses of coronary artery disease, hypertension, end stage renal disease, and chronic obstructive pulmonary disease. The MDS identified the resident received special treatment of oxygen therapy and dialysis treatment.

The Nurse's Notes dated 05/17/2012 at 10:30 a.m. and 2:40 p.m. Staff I attempted to obtain a discharge order for Resident #2. On the same date at 4:45 p.m. the documentation revealed Staff I spoke with the Medical Director of no discharge order obtained. The Medical Director also would not give a discharge order but agreed to an over night pass with spouse. Instructed wife of doctor appointment made for 05/21/2012, medication list given to wife, medications reviewed with resident and wife. Both verbalized understanding. Resident signed out per outing book by spouse. Instructed to call facility with questions. Caregiver assisted resident to private vehicle.

The medical record lacked a written telephone order obtained by the nurse for the physician to sign regarding an overnight leave in the care of the spouse.

During an interview on 05/23/12 at 2:50 p.m. Staff I, Assistant Director of Nursing, stated she did not

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write a phone order, the information was in the nurses' notes.

4. During the Environmental Tour on 5/23/12 at 3:40 P.M. a review of the medication cart for Hall 1 and Hall 4 contained a vial of Lantus insulin stored at room temperature with a pharmacy label marked for Resident #25. The vial lacked the date it was opened for use.

A review of the medication administration record (MAR) revealed an order for Lantus 100 units per milliliter vial, inject 12 units subcutaneously at bedtime.

Staff R confirmed the lack of an opening date and stated it should have been dated.

The manufacturer's prescribing information available on the Internet indicated an open (in-use) vial must be discarded 28 days after being opened. The information went on to read: "if refrigeration is not possible, the open vial can be kept unrefrigerated for up to 28 days away from direct heat and light, as long as the temperature is not greater than 86 degrees Fahrenheit.

5. A review of Resident #21's record revealed an order to discharge to home dated 4/5/12 for the discharge to occur on 4/6/12. A review of the Skilled Daily Nurses Note lacked documentation of a discharge. The documentation indicated a late entry on 4/5/12 of the need to monitor oxygen saturation throughout the night. The documentation for 4/5/12 at 4 P.M. indicated the order for a discharge to home and Resident #21's daughter was aware. On 4/5/12 at 6 P.M. the

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F 281	Continued From page 31 documentation revealed the physician wanted Resident #21 evaluated for the need for home oxygen. The documentation lacked evidence that the physician was asked for clarification of continuing Resident #21's previous orders until the discharge occurred. A Nurse's Note dated 4/7/12 revealed the physician came to see Resident #21 on 4/7/12 at 10:30 a.m. The documentation revealed Resident #21 was discharged at 11:30 a.m. on 4/7/12. Staff I indicated in an interview on 5/24/12 at 6 P.M. the discharge did not occur on 4/6/12 due to the physician wanting to see Resident #21 and review the results of the oxygen saturations for 4/6/12 during the night. The documentation revealed the physician visited at 10:30 on 4/7/12. Record review included a discharge order for 4/7/12 at 11 a.m. to discharge to home.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and observation,	F 282		

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the facility failed to follow the care plan for 4 of 15 residents reviewed (Resident #4, #13, #14, & #15). The facility reported a census of 59 residents.

Findings include:

1. The MDS dated 3/16/12 documented Resident #13 had diagnoses including multiple sclerosis, and anxiety, and neurogenic bladder. The MDS documented the resident as fully dependent on staff for transfers, dressing, personal hygiene and did not walk.

The last care plan update dated 3/28/12 identified a problem with completion of Activities of Daily Living (ADL's) and instructed staff to encourage the resident to wear a sports bra daily.

During observation on 5/16/12 at 7:26 a.m. Staff G, certified nurse aide, and Staff AA, certified nurse aide, assisted the resident to dress the upper body. Staff did not encourage the resident to wear a sports bra and dressed the resident with a t-shirt only.

2. The MDS dated 4/26/12 documented Resident #14 had diagnoses including neurogenic bladder and multiple sclerosis. The MDS documented the resident as fully dependent on staff for all cares and did not ambulate.

The care plan dated 5/9/12 instructed staff to perform range of motion and splint to the right hand per restorative's directive.

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The restorative nursing flow sheet directed staff to perform range of motion to the right hand and apply the splint in the morning and remove at bedtime.

During observation on 5/14/12 at 5:00 p.m. the resident positioned in bed without the right hand splint.

During observation on 5/15/12 at 8:42 a.m. the resident positioned in bed without the right hand splint.

During observation on 5/16/12 at 7:58 a.m. the resident positioned in bed without the right hand splint.

During observation on 5/16/12 at 11:38 a.m. the resident positioned in the bed without the right hand splint.

4. The MDS dated 3/4/12 documented Resident #15 had diagnoses including heart failure and diabetes mellitus. The MDS documented the resident required extensive assistance for cares and did not ambulate.

Review of the clinical record revealed the resident had a history of open areas on the toes.

The care plan dated 3/14/12 included a hand written intervention dated 4/24/12 which instructed staff to utilize a foot cradle to the bed

During observation on 5/15/12 at 7:38 a.m. the resident's bed lacked a foot cradle.

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During observation 5/23/12 at 10:35 a.m. the resident's bed lacked a foot cradle

4. A quarterly MDS dated 3/29/12 identified Resident #4 with the following diagnoses of diabetes, Alzheimer's Dementia, and anxiety disorder. The resident scored 3/15 on the Brief Interview for mental status indicative of both memory and cognitive impairment related to daily decision making skills. The MDS coded the resident required extensive staff assist with bed mobility, dressing, personal hygiene, and bathing. The MDS identified the resident required total staff assist with transfers and toilet use, and limited staff assist for eating. The MDS coded the resident as occasionally incontinent of bowel and frequently incontinent of bladder. The MDS coded the resident with functional limitation in range of motion on one side for the upper extremities and both sides for the lower extremities. The MDS coded the resident with no falls since the prior assessment period.

The resident care plan reviewed on 4/11/12 identified the resident wore glasses for impaired vision. The care plan interventions directed staff assure the glasses are clean and fit properly, assist the resident with placement, and when removing the glasses at night, put them in the red case in the top drawer of the night stand.

Observations made on 5/15/12 at 8:29 a.m. revealed Staff A, LPN, and Staff B, CNA, assisted the resident with dressing and grooming prior to going to breakfast. The staff did not apply the resident's glasses.

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F 282	Continued From page 35 Observations made on 5/16/12 at 9:00 a.m., 9:30 a.m., 10:45 a.m., 11:50 a.m., 12:45 p.m., and 2:00 p.m. revealed the resident without glasses on.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide adequate assessments and interventions for a resident with leg contractures and the inability to fully move legs for bowel incontinent skin cleansing (Resident #1) and failed to assess and provide interventions for bowel management (Resident # 8) and pain management (Resident # 3, #16). The facility reported a census of 59 residents. Resident #1 depended upon staff for activities of daily living needs due to contracture impairments of both legs (hips, knees, ankles and feet). An incident report and nurse ' s notes revealed on 4/29/2012, staff attempted to cleanse the resident after a incontinent bowel episode. The staff heard a pop by the resident ' s left knee and then saw the deformity of the foot bent upwards and towards the resident ' s face. The resident was sent immediately to the hospital and provided	F 309		

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narcotic analgesics, cat scan (revealed the thigh fractured in 3 pieces) and transferred to a Des Moines Hospital for surgery to repair the fractures.

Findings include:

1. Resident #1 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 03/09/12 which identified diagnoses of cerebral palsy and a seizure disorder. The MDS identified the resident required total dependence of two staff for toileting, bed mobility, and transfers. The MDS identified the resident with impairment of functional limitation in range of motion for both sides of the lower extremities (hip, knee, ankle, foot).

The Nurse's notes dated 04/29/12 at 5:08 p.m. revealed the nurse was called to the resident ' s room. The nurse observed the resident lying on left side with left leg bent at the knee facing upwards, foot next to the resident ' s face. The resident ' s vital signs were obtained, physician notified and the resident transferred to the emergency room.

The incident report dated 04/29/12 at 5:10 p.m. revealed a brief summary which revealed two Certified Nursing Assistants changed resident's brief and provided perineal care while the resident lay in bed. The CNA's heard a pop by the resident ' s left knee and then noted the resident ' s foot deformed and bent upward to his/her face.

The local hospital emergency room report dated 04/29/12 documented the resident was brought in by EMS (Emergency Medical Services) and noted

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grossly dislocated left leg. The leg flexed upwards. Staff states they were rolling patient over to change attends (brief) and they heard a pop and the resident ' s leg became dislocated. Staff denied injury, face, or trauma. Patient has CD-morbidities of cerebral palsy and unable to communicate. The document revealed the resident received Morphine (narcotic analgesic/pain medication) 4 milligrams at 6:05 p.m., 6:35 p.m. and 6:45 p.m. The record further documented additional pain medication of Fentanyl 50 micrograms (narcotic analgesic) administered at 6:50 p.m. and 7:13 p.m.

A radiology report dated 04/29/12 revealed a computed tomography (CT exam) with findings of a complex comminuted fracture of the left femur (thigh). There is angulation at the fracture site. Chronic degenerative changes of the hip joint with chronic subluxation. SI joints and right hip are unremarkable. Changes of osteopenia.

Resident #1 was transferred to another hospital for surgery in Des Moines Iowa and arrived at 8:50 p.m. on 4/29/2012. An orthopedist examined the resident and ordered 5 pounds of traction until an open reduction internal fixation surgery could be performed. The Emergency Room staff obtained photographs of the resident ' s leg.

The Operative Report indicated the resident had surgery on 5/1/2012 for repair of the fractures. The report indicated the femur had 3 comminuted (fracture in pieces) fractures in 3 parts. The procedure consisted of an intramedullary nail fixation of the left subtrochanteric femur fracture with an open reduction technique.

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The hospital Patient Discharge & Transfer Form indicated the date of discharge to be 5/4/2012. The orthopedic physician had ordered physical therapy, weight bearing status from bed to chair. Change the dressing daily until dry and put Betadine on the incision. Provide Fragmin (anticoagulant) 5,000 IU (international units) subcutaneously for 30 days after admission. The order directed the resident to return in 2 weeks for a follow up appointment. The resident ' s physician admission orders directed the staff to use a Hoyer lift for transferring the resident.

The physical therapy notification identified a discharge date of 5/8/2012. The therapist ordered passive range of motion to both upper extremities for 10 repetitions and passive range of motion to knees, ankles and toes for 10 repetitions. The therapist instructed staff to keep the arm support in the geriatric chair for the left side and keep an abduction wedge between thighs while monitoring for wincing for the pain level.

Observation on 05/16/2012 at 8:04 a.m. revealed Resident #1 in bed and the bilateral lower leg extremities contracted in a scissor like position; left leg over the right crossed at knees. The resident had an incision along the left femur.

During an interview on 05/22/12 at 1:10 p.m. Staff W provided a written statement: the resident was laying on his/her back and had a very large bowel movement. I was holding his/her left leg up so that Staff X could clean well between his/her legs. He/she was resisting and then I heard a pop and his/her left leg just fell to the head of the bed. I hurried and ran out and got charge nurse. During

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the interview, Staff W reported no education or special way to provide incontinence care for a resident with severely contracted lower extremities.

On 05/22/12 at 2:00 p.m. Staff X was interviewed and provided a written statement: Staff W and I went to prepare for care and the resident had BM (bowel movement) up tɒ his/her belly button. During cares I heard a snap/crack and Staff W looked and his/her foot was touching the forehead. I then told Staff W to go get the nurse. Staff X commented she had no education or special way to provide incontinence care for the resident.

The care plan at the time of the incident did not identify the resident with limited physical mobility due to leg contractors (crossed) and how staff should provide activities of daily living (ADL) cares. The interviews and record review revealed the facility had not provided additional training to staff regarding how to care fɒr the resident with lower leg contractures post injury.

2. Resident #3 had a Minimum Data Set assessment with a reference date of 04/05/2012 which identified Resident #3 with diagnoses of Alzheimer's disease and osteoporosis. The medical record revealed the resident had a history of a compression fracture of the lumbar one vertebra. The assessment indicated the resident received a scheduled pain medication regimen and a PRN (as necessary) pain medication. A pain evaluation dated 7/6/2011 identified the resident had a diagnosis of a compression fracture of the lumbar #1 vertebrae and the resident verbalized pain. The conclusion

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dated 10/20/11 indicated the resident received Fentanyl patch 12 mcg/hr and changed every 72 hours. On 1/10/2012 the evaluation revealed no change. On 4/12/2012 the pain assessment identified the resident as restless and moans. Fentanyl and PRN Tylenol to be continued.

A monthly summary dated 5/21/2012 identified the resident had frequent pain. The summary did not identify indicators of pain (non-verbal sounds, vocal implants, facial expressions, protective body movements or postures).

The care plan dated 04/18/2012 identified the resident had a difficult problem with making self understood, often restless, fidgety and words noted as garbled and hard to understand. An approach directed staff to observe for non-verbal signs of distress (guarding, moaning, restlessness and grimacing). Turn/reposition, communicate, provide pericare, assess for pain and provide liquids/food as needed.

Observation on 05/14/12 at 5:13 p.m. revealed the resident in the front lounge sitting in a geriatric chair with sad facial expressions, frown brow, with grimacing noted, and crying. Registered Nurse attends to resident ' s side, holding hand. The nurse reported the resident gets " this way " at this time of day.

Observation on 05/15/12 at 8:38 a.m. revealed the resident in his/her bed with sad facial expression.

Observation on 05/15/12 at 3:10 p.m. noted the resident in the front lounge crying with frowned brow. A staff member provided the resident with

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a drink of water.
Observation on 05/16/12 at 11:07 a.m. revealed two CNA's ambulating the resident with a gait belt from the bathroom to his/her geriatric chair in the front lounge. Observation revealed the resident with frowned brow, sad facial expression and making repetitive sounds.

A nurse sent a facsimile on 4/11/2011 which identified the Fentanyl 12 mcg (micrograms) had been changed the previous night and had fallen off. The patch could not be found. The nurse requested an order to replace the patch. On 4/11/2012, the physician gave approval.

The Physician Progress Notes dated 5/9/2012 indicated the physician discontinued the Fentanyl patch and ordered Acetaminophen (Tylenol) liquid 500 milligrams twice a day. The record revealed no documentation of a pain assessment or reason for the discontinuation of the narcotic analgesic. The May Medication Administration Record (MAR) revealed the last day for the application of the Fentanyl patch on the resident to be 5/6/2012.

On 05/22/12 at 9:40 a.m. Staff GG, Licensed Practical Nurse, reported she thought the Fentanyl patch was discontinued due to it falling off the resident. Staff GG stated the resident is given the Tylenol and Ativan but the resident spits it out. Staff GG stated she had not noticed any changes in the resident but thinks the Fentanyl patch would give the resident more relief. (especially when the resident spit out the medication)

3. Resident #16 had an MDS assessment with a

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reference date of 2/16/12. The assessment documented the resident had diagnoses including heart failure, diabetes mellitus, stroke, anxiety, kidney disease, dementia, and hypothyroid. The MDS documented the resident received scheduled pain medication. The MDS documented the resident as totally dependent on staff for cares and did not walk. The MDS documented the resident had long and short term memory loss as well as severely impaired decision making abilities.

The care plan dated 2/29/12 documented the resident has behaviors of yelling out and delusions. The care plan documented the resident utilized Tylenol for pain control and had an order for Tylenol with Codeine for severe pain. The care plan failed to direct staff to assess the resident for pain.

During observation on 5/15/12 in the afternoon, the resident yelled and had delusions of people trying to kill her/him.

Observation on 5/21/12 at 3:35 p.m. revealed the resident in bed yelling for help.

The May 2012 Medication Administration Record (MAR) documented the resident could receive pain medication Tylenol with codeine four times as needed and Haldol (antipsychotic medication) every four hours as needed.

Review of the MAR 2012 documented staff failed to administer pain medication on 5/15/2012.

Review of the MAR for April 2012 the resident received as needed pain medication three times

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and did not receive any as needed antipsychotic medication.

Review of the MAR for March 2012 the resident received as needed pain medication three times and did not receive any as needed antipsychotic medication.

Review of the MAR for February 2012 the resident received as needed pain medication once during the month.

Review of the MAR for January 2012 the resident received as needed pain medication 5 times and did not receive any as needed antipsychotic medication.

4. A quarterly MDS assessment with a reference date of 3/29/12 identified Resident #8 with diagnoses of Alzheimer's Disease and depression. The assessment reflected toileting did not occur during the assessment period; however, the resident was identified as always incontinent of bowel and bladder function. The assessment indicated the resident did not have a toileting program.

The Resident Care Plan dated 4/11/2012 identified a problem with the resident unable to perform any activities of daily living skills. The approaches directed staff to check and change at least every 2 hours for incontinence and not to let the resident go more than 2 days without a bowel movement.

A physician order sheet dated 4/1/12 to 6/30/12 (not yet signed by the physician), gave the following orders Docusate Sodium (stool

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softener) 100 mg (milligrams) 1 capsule daily, Miralax Powder (laxative) 17 gm (grams) in 8 ounces of water or juice daily after supper, Bisac-Evac 10 mg Suppository rectally once daily as needed for constipation , Bisacodyl 5 mg tablet 1 daily at breakfast as needed for constipation, and Milk of Magnesia (laxative) 30 ml (milliliters).

The February Bowel Movement record revealed Resident #8 did not have a bowel movement 2/5/2012, 2/6/2012 and 2/7/2012. The resident had a large bowel movement on 2/8/2012. The resident went from 2/12/12 to 2/15/12 without a recorded BM, from 2/18/12 to 2/22/12 with an XS (extra small) BM recorded due to receiving a Dulcolax suppository on 2/22/12 to aide in bowel evacuation. This is the only date according to the MAR that the resident received any additional as needed laxatives to aide in bowel evacuation for the entire month of February.

The March Bowel Movement record revealed Resident #8 had a large BM on 3/2/12 and didn't have a recorded BM until 3/9/12. According to the MAR the resident received A Dulcolax suppository rectally on 3/6/12 without any recorded results. The bowel record documented the resident with a BM on 3/23/12 and a large BM recorded on 3/27/12. Again the resident went from 3/27/12 to 3/31/12 when staff documented a small BM. The March MAR revealed the resident received no additional as needed laxatives during these spans to promote successful bowel evacuation.

The April Bowel Movement record revealed the resident went from 4/1/12 to 4/5/12 without a recorded BM. On 4/5/2012 the resident had a

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F 309	Continued From page 45 large bowel movement. from 4/6/12 to 4/13/12 without a recorded BM, from 4/11/12 to 4/13/12, and 4/27/12 to 4/29/12 without recorded BM's. The April MAR revealed no as needed laxatives administered for the month to assist the resident in adequate bowel evacuation and to follow the care plan to let no more than 2 days go by without the resident evacuating the bowels.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy review, and observation, the facility failed to provide complete incontinence care for 1 of 10 residents reviewed with incontinence (Resident #8) and failed to provide showers for 1 of 16 resident reviewed (Resident #16). Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/16/12 documented Resident #16 had diagnoses including heart failure, diabetes mellitus, stroke, anxiety, kidney disease, dementia, and hypothyroid. The MDS documented the resident as totally dependent on staff for bathing. The care plan dated 2/29/12 did not address	F 312		

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showers or bathing.

The shower logs for March 2012 documented the resident received showers on Monday and Thursdays

The shower log documented one shower the week of March 4-10th, one shower the week of the 11th -17th, one shower the week of the 18th-24th, and one shower the week of the 25th-31st.

The shower log for April 2012 documented one shower the week of the 15th-21st and one shower 22nd-28th.

The shower log for May 2012 documented the resident received one shower the week of April 30-May 3, 2012.

2. A quarterly MDS dated 3/29/12 identified Resident #8 with the following diagnoses of Alzheimer's Disease and depression. The MDS coded the resident with both memory impairment and severely impaired cognitive function related to daily decision making skills. The MDS coded the resident as totally dependent upon staff for bed mobility, transfers, dressing, eating, personal hygiene, and bathing. Toileting did not occur during the assessment look back period. The MDS coded the resident with no functional limitation in range of motion. The MDS identified the resident as always incontinent of bowel and bladder function.

The resident care plan reviewed on 4/11/12 identified as a problem the resident incontinent and requiring total assistance with all activities of

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daily living. One of the interventions included directed the staff to check and change at least every 2 hours for incontinence and not to let the resident go more than 2 days without a bowel movement. The care plan also directed staff to provide incontinence care twice daily and as needed after each incontinent episode apply barrier cream.

An observation made on 5/16/12 at 5:50 a.m. revealed Staff C, CNA, donned gloves without first washing her hands. Staff C placed some dark blue colored washcloths at the sink side and then wet them with water from the room sink. Staff C set 2 plastic bags at the foot of the resident's bed and checked the resident's incontinent brief and verified it to be wet. Staff C turned off the sink faucet with a gloved hand, applied body wash cleansing lotion to the washcloth, set the washcloth down on the bedding beside the left siderail, picked it up and began cleansing the right groin, inner labia using a clean corner of the washcloth for each wipe. Staff C took a clean wet washcloth and cleansed the left hip, left buttock, turned the cloth to a clean corner, cleansed the peri-rectal area, right upper thigh washing back and forth using the same area of the washcloth for all areas cleansed. Staff C removed the incontinent brief, and then removed her gloves. Staff C donned clean gloves, again turned on the water faucet with a gloved hand, and wet another washcloth and applied body wash solution, and turned off the water with a gloved hand.
Staff C cleansed the peri-rectal area again, rolled the resident onto the left hip, washed the right hip back and forth using the same area of the washcloth. Staff C removed her gloves, donned

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a clean pair of gloves, and rolled the resident onto the right hip. Staff C applied the clean incontinent brief, removed her gloves, and secured the brief in place. Staff C positioned the resident onto the right side with a body pillow up against the resident's left side, floated the heels on a small pillow, and covered the resident with a blanket.

The skills checklist for incontinent care dated 7/07 instructed staff to perform the following tasks:

Put on gloves

Removed soiled items

Remove gloves and reapply if soiled

Cleanse the resident's genital area

Change cloth or cloth surface with each wipe

Turn resident to the side

Wash buttocks and upper thighs front to back

Apply moisture barrier if applicable

Remove gloves.

F 314 SS=G 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES — F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that

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they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and review of the Quick Reference Guide for Clinicians, the facility failed to ensure one resident received appropriate interventions for repositioning off pressure ulcers and provide complete and accurate assessments of ulcers for 1 of 15 sample residents (Resident #2). Interventions were ineffective to prevent the occurrence of an avoidable additional pressure ulcer or were not implemented as directed on the care plan. The facility reported a census of 59 residents.

Upon admission on 5/3/2012, Resident #2, facility staff identified 2 pressure sore areas located on the resident ' s left and right outer ankle, fifth right digit and anterior area of the right foot. On 5/4/2012 the facility staff identified a black area located on the resident ' s left heel. On 5/6/2012, the staff sent a facsimile to the physician for orders for an air mattress and heel protectors. The initial care plan dated 5/3/2012 and current care plan directed staff to use heel protectors to relieve pressure on the heels. The initial admission care plan approach directed staff to have an air mattress located on the bed.
A facsimile to the physician on 5/14/2012 indicated the facility had identified another pressure ulcer located on the right heel which measured 2 centimeters (cm) by 2 cm and brown. The facsimile informed the physician the facility

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did not have a treatment order for the heels. On 5/14/2012 at 6:00 p.m., the physician ordered an " okay " for heel protectors and to keep the heels off of the bed. The wound assessment records determined on 5/14/2012, the left heel pressure ulcers had enlarged and an additional pressure ulcer had become present on the right heel. Observation revealed the heel protective boots not always on the resident ' s feet when the resident lay in bed on 5/15/12, 5/16/12, 5/17/12.

Findings include:

1. Information from the Quick Reference Guide for Clinicians regarding pressure ulcer treatment includes the following:
- Stage I: Nonblanchable erythema of intact skin.
- Stage II: partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
- Stage III: full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.
- Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.
- Reassess pressure ulcers at least weekly.

1. The Minimum Data Set (MDS) Assessment Tool with a reference date of 05/10/2012 identified Resident #2 with diagnoses of coronary artery disease, hypertension, end stage renal disease and chronic obstructive pulmonary disease. The MDS reflected the resident required 1 staff person with limited assistance for bed

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mobility, transfers and ambulation. The MDS identified the resident at risk for developing pressure sores and identified the resident with two unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. The largest unhealed wound at the time of the assessment documented the wound measured 1.5 centimeters in length and 1.0 centimeters in width with necrotic tissue (eschar - a black, brown, or tan that adheres firmly to the wound bed or ulcer edges). The MDS reflected the resident received pressure ulcer care, pressure reducing device for the bed. The MDS reflected the resident did not have a turning/repositioning program or pressure reducing devices for the feet

The Braden Scale for Predicting Pressure Sore Risk dated 05/03/12 revealed a score of 18 with a score of 12 or less indicated a high risk for skin breakdown.

The initial care plan dated 05/03/12 identified a concern for pressure sores/skin care with a goal to prevent/heal pressure sores and skin breakdown. Interventions listed: to follow the facility skin care protocol, preventative measures with use of heel protectors/air mattress, and report to charge nurse any redness or skin breakdown immediately.
A skin condition report dated 05/03/12 revealed the following skin issues:
a. The left outer ankle noted a brown scab that measured 0.4 centimeters by 0.4 centimeters (cm).
b. The right outer ankle noted a 3 cm callous area with a 0.3 cm brown center.
c. The top of the right foot noted a 1.0 cm by 0.4 cm reddish open area.

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d. The right outer 5th toe of the right foot noted a 0.3 cm by 0.3 cm black scab.

A skin condition report dated 05/04/12 documented a left heel black scab like area that measured 1.5 centimeters in length.

A facsimile (fax) dated 05/04/12 requested treatments for the skin concerns.
A wound assessment dated 05/06/12 revealed the following measurements:
a. The left heel revealed a dark scab that measured 1.0 cm by 1.0 cm.
b. The left outer heel revealed a 0.3 cm by 0.5 cm scab and 1.0 cm by 3.0 cm callous.
The assessment revealed a fax sent for treatment with an air mattress and heel protectors.

A wound assessment dated 05/14/12 revealed the following measurements:
a. The left heel revealed a scab that measured 1.5 cm by 1.0 cm (increased in size).
b. The left outer heel revealed a 0.5 cm scab and 1.0 cm by 3.0 cm callous.
c. The right heel revealed a wound that measured 2.0 cm by 2.0 cm with a wound bed as brown in color and intact (new area).

The Treatment record for May 2012 revealed a treatment to monitor the following areas:
a. Monitor left heel.
b. Monitor left outer heel.
c. Monitor left outer ankle.
d. Monitor top of right foot, right outer pinky, and fourth toe (right) for ten days then weekly till healed.
e. Float heels/heel protectors as resident allows.

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F 314	Continued From page 53 The Treatment record dated 05/14/12 revealed a treatment to the left and right heel of skin prep twice daily. Observations on the following dates and times revealed no use of the heel protective boots while the resident laid in bed. a. On 05/15/12 at 7:30 a.m. b. On 05/16/12 at 4:35 a.m. c. On 05/17/12 at 7:33 a.m. Observation on 05/17/12 at 10:30 a.m. revealed Staff Y, Registered Nurse, provided skin prep treatment to the resident's right and left heels. Observation revealed black wounds to the resident's right and left heel, 5th toe, and fourth digit. Staff Y completed the treatment and placed the resident's shoes on his/her feet. Record review lacked documentation of the refusals for wound treatments or education provided of the importance of care.	F 314		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation,	F 318		

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facility flow sheets, and staff interview, the facility failed to provide range of motion exercises as planned for 5 of 16 residents reviewed (Resident #4, #10, #13, #14, & #16). The facility reporrted a census of 59 residents.

Findings include;

The range of motion for active, active assistance, and passive flow sheet lists the following exercises:

Neck extension/flexion

Neck lateral flexion

Rotation of neck

Shoulder extension/flexion

Shoulder flexion

Shoulder vertical abduction/adduction

Shoulder adduction

Shoulder abduction

Shoulder horizontal abduction/adduction

Shoulder internal rotation

Shoulder external rotation

Elbow extension/flexion

Forearm supination/pronation

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Wrist flexion/extension

Wrist lateral flexion

Wrist circumduction

Finger and thumb extension/flexion

Finger and thumb adduction/abduction

Finger and thumb opposition

Finger and thumb circumduction

Hip and knee extension/flexion

Hip and knee abduction/adduction

Hip and knee internal/external rotation

Ankle dorsiflexion/plantar flexion

Ankle circumduction

Foot inversion/eversion

Toes extension/flexion

Toes abduction/adduction

1. The Minimum Data Set assessment dated 4/5/12 documented Resident #10 had diagnoses including Alzheimer's disease, anxiety, and a psychotic disorder. The MDS documented the resident scored a 7 on the brief interview for mental status indication memory impairment and impaired recall. The MDS documented the

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resident required extensive assistance with transfers and moderate assistance for walking, dressing, eating, and personal hygiene. The MDS documented the resident had no range of motion impairments.

The care plan dated 4/18/12 instructed staff to walk the resident in the hallway to and from meals.

The restorative nursing record for March 2012 lacked documentation staff walked the resident to and from breakfast on the 1st, 2nd, 3rd, 4,6th, 9, 17th, 23rd, and 24th.

The restorative nursing record for March 2012 lacked documentation staff walked the resident to and from lunch on 1st, 2nd, 3rd, 5, 9th, 10th, 13rd, 17th, 21st, 23rd, 24th, and 26th.

The restorative nursing record for March 2012 lacked documentation staff walked the resident to and from supper on the 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 18, 19 2024, 25,26,27,28,30 and 31.

The restorative nursing record for April 2012 lacked documentation staff walked the resident to and from breakfast on the 3, 5th, 6th, 7th, 11th, 12th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 21st, 24th, 25th, 26th, 27th, and 28th.

The restorative nursing record for April 2012 lacked documentation staff walked the resident to and from lunch on 3rd, 5th, 6th, 7th, 11th, 12th, 13th, 14th, 15th, 16th, 18th, 19th, 20th, 21st, 24th, 25th, 26th, 27th, and 28th.

The restorative nursing record for April 2012

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lacked documentation staff walked the resident to and from supper on the 1st, 4th, 5th, 6th, 7th, 14th, 21st, 22nd, and 30th.

The restorative nursing record for May 2012 directed staff to provide active range of motion for 15 minutes. Ambulation to and from meals of 100 feet may be recorded on thee CNA book.

During observation on 5/16/12 at 11:00 a.m. Staff A, licensed practical nurse, assisted the resident to walk to the rehabilitation room. The resident performed pulley exercises for four minutes, the range of motion arch for three minutes, and then the arm bicycle. Staff A assisted the resident with another resident to complete lower extremity exercises. The resident performed leg stretches five times and some leg abduction exercises. Staff A did not complete the resident's program by performing all the arm exercises, neck, wrist, fingers, legs,ankle, and toes as outlined in the list of exercises Staff A provided for range of motion.

2. The MDS dated 3/16/12 documented Resident #13 had diagnoses including multiple sclerosis, and anxiety, and neurogenic bladder. The MDS documented the resident as fully dependent on staff for transfers and did not walk. The MDS documented the resident had range of motion impairment in the lower extremities.

The restorative nursing flow sheet for February 2012 instructed staff to perform active and passive range of motion exercises to all extremities three times a week. The flow sheet documented the resident received range of motion twice February 23th-February 29.

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The restorative nursing flow sheet for March 2012 documented the resident received range of motion once March 4th-11th, twice March 11th-17th, twice March 18th-24th, and twice March 25th-31.

The restorative nursing flow sheet for April 2012 documented the resident received range of motion twice during the April 8th-14th time frame and twice March 22nd-28th time frame.

During observation on 5/16/12 at 11:15 a.m. the resident performed pulley exercises, range of motion arch and one pound hand weights. Staff A, licensed practical nurse, helped the resident intermittently but did not assist the resident with all the neck, arm, wrist, and finger exercises. Staff A assisted the resident with lower extremities. The resident performed leg stretches. Staff A did not assist the resident with all the leg, knee, foot, and toe exercises.

3. The MDS dated 4/26/12 documented Resident #14 had diagnoses including neurogenic bladder and multiple sclerosis. The MDS documented the resident as fully dependent on staff for all cares and did not ambulate. The MDS documented the resident had upper and lower range of motion impairment.

During observation on 5/21/12 at 10:35 a.m. Staff T, restorative aide, assisted passive range of motion for the resident. Staff T performed arm, elbow, wrist, fingers, legs, knee, ankle, and toe exercises. Staff T failed to perform passive range of motion neck exercises.

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4. The MDS assessment dated 2/16/12 documented Resident #16 had diagnoses including heart failure, diabetes mellitus, stroke, anxiety, kidney disease, dementia, and hypothyroid. The MDS documented the resident as totally dependent on staff for cares and did not walk. The MDS documented the resident had range of motion impairment to the upper and lower body.

The restorative nursing flow sheet directed staff to assist with range of motion exercises 3 times a week.
The restorative nursing flow sheet for March 2012 documented the resident received range of motion once the 5th through the 10th, once the 11th through the 17th, once the 18th through the 24th, and once the 25th through the 31st.

During an interview on 5/21/12 at 8:30 a.m. Staff T, licensed practical nurse, stated she followed a flow sheet listing all the exercises to provide range of motion to all planes.

During an interview on 5/21/12 at 9:55 a.m. Staff DD, physical therapy assistant, stated the arm bike and pulleys does not provided complete range of motion of the upper body. Staff DD stated the restorative aide needed to follow the resident's restorative program.

5. A quarterly MDS (Minimum Data Set Assessment) dated 3/23/12 identified Resident #4 with the following diagnoses of diabetes, Alzheimer's Dementia, and anxiety disorder. The resident scored 3/15 on the Brief Interview for mental status indicative of both memory and

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cognitive impairment related to daily decision making skills. The MDS coded the resident required extensive staff assist with bed mobility, dressing, personal hygiene, and bathing. The MDS identified the resident required total staff assist with transfers and toilet use, and limited staff assist for eating. The MDS coded the resident as occasionally incontinent of bowel and frequently incontinent of bladder. The MDS coded the resident with functional limitation in range of motion on one side for the upper extremities and both sides for the lower extremities. The MDS coded the resident with no falls since the prior assessment period. The MDS coded the resident received passive range of motion on 2 of the 7 days during the assessment look-back period.

The resident care plan reviewed on 4/12/12 identified as a problem area a need for assistance with all activities of daily living due to a history of a hip and arm fracture resulting in the resident being non-ambulatory. Included in the interventions: 3. Restorative program for exercise and transfers.

The December Restorative Nursing sheet revealed the resident to receive PROM (Passive Range of Motion) to all extremities 10 - 15 repetitions 6 times per week. The record revealed the resident received it only 4-5 times weekly. The monthly documentation summary indicated no change in the resident's condition.

The January Restorative Nursing sheet revealed the resident received PROM to all extremities 10-15 repetitions 6 times per week. The record revealed the resident received the restorative

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PROM program 5 times the first 2 weeks of the month and only 2 times a week for the last 2 weeks of the month. The monthly documentation indicated to continue with the current restorative program.

The February Restorative Nursing sheet revealed the resident to receive PROM exercises 15 repetitions for each exercise only 3 times per week now instead of 6 during the prior 2 months without any explanation given as to why the frequency changed for this month. The resident received PROM 3 times per week for the first 3 weeks of the month and only 1 time during the last week of the month. The February Monthly documentation indicated the continue to maintain current level of function, continue with the current functional maintenance plan and continue with the restorative program.

The April Restorative Nursing sheet directed the resident received PROM to all extremities 15 repetitions 3 times a week. The documentation revealed the resident received PROM exercises 2 times a week for the first 2 weeks of the month and 5 times a week for the last 2 weeks of the month. The monthly documentation revealed to continue with the current restorative program for the month of May.

An observation made on 5/16/12 at 12:35 p.m. to 12:50 p.m. revealed Staff A, LPN/RA (Licensed Practical Nurse and Restorative Aide), performed PROM exercises to the resident. Staff A completed on 10 repetitions of each exercise instead of 15 as directed on the restorative sheet. The resident demonstrated cooperation during the exercise session.

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to maintain safe water temperatures (below 120 degrees Fahrenheit) for residents and failed to provide adequate supervision to ensure the residents' safety for 3 of 15 residents reviewed (Resident #10, #13, and #15). The facility reported a census of 59 residents.

Findings include:

1. Observation during the initial environmental tour on 05/14/12 at 11:05 a.m. revealed the following hot water temperatures:
a. At 11:36 a.m. the conference room bathroom revealed a water temperature of 132 degrees Fahrenheit.
b. At 11:42 a.m. nurse's station number two revealed a water temperature of 126.9 degrees Fahrenheit.
c. At 11:45 a.m. the conference room bathroom revealed a water temperature of 129 degrees Fahrenheit.
d At 11:48 a.m. room 202 revealed a water temperature of 128.1 degrees Fahrenheit and

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Staff N, maintenance, using a facility thermometer got a reading of 129 degrees Fahrenheit.
e At 11:54 a.m. the beauty shop revealed a water temperature of 127.2 degrees Fahrenheit and Staff N, using a facility thermometer, got an reading of 127 degrees Fahrenheit.
f. At 11:56 a.m. the 200 hall shower room sink revealed a water temperature of 132.9 degrees Fahrenheit and Staff N, using a facility thermometer, got an reading of 131.2 degrees Fahrenheit.

Staff N reported that the rooms identified with concerns were on the same hot water tank. Staff N turned the hot water heater down by one notch

Follow up on 5/14/12 at 4:48 P.M. found the water temperature in the Conference room at 113.9 degrees Fahrenheit. The Nurses' Station 2 was 103.5 degrees Fahrenheit. Room 202 was 110.1 degrees Fahrenheit and the shower room on hall 2 was 107.2 degrees Fahrenheit.

2. The Minimum Data Set assessment dated 4/5/12 documented Resident #10 had diagnoses including Alzheimer's disease, anxiety, and a psychotic disorder. The MDS documented the resident scored a 7 out of 15 on the brief interview for mental status indicating memory impairment and impaired recall. The MDS documented the resident required extensive assistance with transfers and moderate assistance for walking, dressing, eating, and personal hygiene. The MDS documented the resident had a history of falls.

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The care plan 4/18/12 documented the resident had a history of falls. The care plan did not indicate the resident could not utilize the call light.

During observation on 5/14/12 at 4:50 p.m. the resident lay in bed without an accessible call light.

During observation on 5/16/12 at 6:30 a.m. the resident lay in bed without an accessible call light.

3. The MDS dated 3/16/12 documented Resident #13 had diagnoses including multiple sclerosis, and anxiety, and neurogenic bladder. The MDS documented the resident was dependent on staff for transfers and did not walk. The MDS documented the resident had a history of falls.

The care plan dated 3/28/12 documented the resident at risk for falls and poor safety awareness. The care plan instructed staff to assist to bed after meals and to not leave the resident in the room in the wheelchair unattended as the resident will attempt to self transfer.

During observation on 5/15/12 at 10:15 a.m. the resident sat in the wheelchair unattended in the room.

4. The MDS dated 3/4/12 documented Resident #15 had diagnoses including heart failure and diabetes mellitus. The MDS documented the resident required extensive assistance for cares and did not ambulate. The MDS documented the resident had lower extremity impairment.

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The care plan identified the resident used a motorized wheelchair but lacked interventions to ensure the resident used the chair safely to prevent injury to him/herself or others.

A facsimile dated 4/3/12 documented the resident had open areas to the left shin and right great toe.

A facsimile dated 5/6/12 documented open areas to the left second toe, right lower buttocks, right shin, left shin and bruising to the left hand and right shin. The resident stated he/she bumped the right leg on 5/5/12.

A facsimile dated 5/14/12 documented the resident had open areas on the left shin, left 2nd toe, and right shin. The resident had bruising to the left wrist and left hand.

The restorative nursing program dated 1/3/12 documented a trial of the resident using an electric wheelchair. The program instructed the resident to utilize a seat belt and Dycem on the foot pedal to prevent sliding.

During observation on 5/15/12 at 7:33 a.m. the resident had a band aid to the left 3rd toe, dressing to left inner shin, and dressing to the right outer shin. Staff G, certified nurse aide, and Staff CC, certified nurse aide, stated the resident frequently ran into things while in the electric wheelchair.

During an interview on 5/30/12 at 10:00 a.m. Staff EE, occupational therapist, stated she did the initial evaluation in January to assess if the resident could safely operate the electric

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F 323	Continued From page 66 wheelchair. Staff EE stated the facility did not communicate to her the resident had bumped his/her legs resulting in skin tears. Staff EE stated if the facility reported the information to her, she would complete another evaluation.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, dietitian and staff interview, the facility failed to follow all interventions on the care to ensure the resident received the nutrition recommended by the dietitian to prevent weight loss for 1 of 3 residents reviewed with weight loss (Resident #15). The facility reported a census of 59 residents. Findings include: 1. The Minimum Data Set (MDS) dated 3/4/12 documented Resident #15 had diagnoses including heart failure and diabetes mellitus. The MDS documented the resident required extensive	F 325		

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assistance for cares and did not ambulate. The MDS documented the resident ate independently. The MDS documented the resident weighed 237 pounds and had a height of 72 inches.

The nutritional history documented the resident weighed 252 pounds and documented the resident received skim milk with meals.

The dietary progress note dated 9/30/11 documented the resident admitted with a regular diet with skim milk at meals.

The dietary progress notes dated 12/22/11 documented the resident readmitted from the hospital on a regular small portion diet.

The dietary progress note dated 1/6/12 documented the dietitian recommended a high protein snack at bedtime.

The dietary progress note dated 1/12/12 documented the resident started on a multivitamin and 2 ounces of a liquid supplement.

The dietary progress note dated 2/7/12 documented a weight on 234 pounds and documented the resident wanted the weight loss.

The dietary progress note dated 2/28/12 documented the resident readmitted from the hospital on a regular small portion diet and weighed 237 pounds.

The dietary progress note dated 3/12/12 documented the resident continues to receive a high protein snack and had no further recommendations.

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The dietary progress note dated 4/23/12 documented a weight of 223 pounds and had a open area on the right buttock. The dietitian recommended 2 ounce liquid supplement.

The dietary progress notes dated 5/8/12 documented a weight of 223 pounds which calculated a loss of 6.3% in 30 days and 12.5% in 6 months. The progress note documented the resident received a high protein snack at bedtime and 2 ounces of liquid supplement.

During observation on 5/15/12 at 8;35 a.m. dietary staff provided corn flakes, pancake, milk, iced tea, and cranberry juice.

At 8:55 a.m. the resident finished breakfast. The resident ate the corn flakes and drank all fluids provided.

During an interview on 5/21/12 at 3:42 p.m. Staff BB, certified nurse aide, stated the resident received a peanut butter and jelly sandwich at bedtime but often refuses the sandwich. Staff BB stated she did not document whether the resident received the snack.

During an interview on 5/22/12 at 10:25 a.m. Staff K, dietary manager, stated dietary staff did not keep a record of the consumption of the resident's bedtime snack.

During an interview on 5/23/12 at 3:05 p.m. Staff V, certified nurse aide, stated the resident did not receive a peanut butter and jelly sandwich at bedtime and most of the time refuses snacks.

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F 325	Continued From page 69 During an interview on 6/1/12 at 10:33 a.m. Staff P, dietitian, stated a high protein snack would consist of a peanut butter sandwich, 1/2 meat sandwich, cottage cheese, or yogurt. Staff P stated the facility had no formal way to track the resident's bedtime snack. Staff P stated in the past, staff documented the consumption of the snack of the medication administration record but no longer tracked the consumption of the snack.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility staff failed to encourage or offer fluids during observed cares for 3 of 4 residents at risk for dehydration (Resident #1, #6, and #7). The facility failed to have consistent tracking methods for 1 of 1 residents revived on fluid restrictions (Resident #2). The facility reported a census of 59 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment Tool dated 03/09/12 identified Resident #1 with diagnoses of cerebral palsy and a seizure disorder. The MDS identified Resident #1 with short and long term memory problems and severely impaired for cognitive skills for daily decision making. The MDS revealed the resident rarely or never made self understood for hearing,	F 327		

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speech, and vision. The MDS identified the resident required total dependence of one staff for eating.

The care plan identified Resident #1 with difficulty in understanding others, and not able to make own needs known. The approach revealed staff to anticipate needs as unable to communicate. The care plan identified the resident at risk for malnutrition/weight loss due to being unable to feed self.

Observation on 05/16/12 at 8:04 a.m. revealed Staff G and Staff AA, Certified Nursing Aides, provided cares for the resident. Observation revealed staff failed to offer fluids.

2. The Minimum Data Set (MDS) Assessment Tool dated 03/02/12 identified Resident #6 with diagnoses of cerebral palsy, dementia, an enlarged prostrate - use of an indwelling catheter, and a seizure disorder. The MDS identified Resident #6 with short and long term memory problems and severely impaired for cognitive skills for daily decision making. The MDS revealed the resident rarely or never made self understood for hearing, speech, and vision. The MDS identified the resident required total dependence of one staff for eating.

The care plan identified Resident #6 with difficulty in understanding others, and not able to make own needs known. The approach revealed staff to anticipate needs as unable to communicate. The care plan identified the resident at risk for weight loss due to being unable to feed self.

Observation on 05/15/12 at 11:25 a.m. revealed

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Staff G and Staff B, Certified Nursing Aides, provided cares for the resident. Observation revealed staff failed to offer fluids.

3. The Minimum Data Set (MDS) Assessment Tool dated 03/23/12 identified Resident #7 with diagnoses of Alzheimer's disease, renal insufficiency, heart failure, and paraplegia. The MDS identified the resident with short and long term memory problems and severely impaired for cognitive skills for daily decision making. The MDS revealed the resident sometimes made self understood for hearing, speech, and vision. The MDS identified the resident required total dependence of one staff for eating and had an indwelling catheter.

The care plan identified Resident #7 diagnoses of Alzheimer's disease and epilepsy, identified a goal to drink ally fluids, and an approach to offer fluids frequently throughout the day.

Observation on 05/15/12 at 11125 a.m. revealed Staff G and Staff B, Certified Nursing Aides, provided cares for the resident. Observation revealed staff failed to offer fluids.

4. The Minimum Data Set (MDS) Assessment dated 05/10/2012 identified Resident #2 with diagnoses of coronary artery disease, hypertension, end stage renal disease, chronic obstructive pulmonary disease. The MDS identified the resident received special treatment of oxygen therapy and dialysis treatment.

A physician order dated 05/08/12 revealed an order for a 1500 milliliter fluid restriction.

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F 327	Continued From page 72 The facility fluid restriction guidelines for the 1500 milliliters revealed nursing was allowed 18 ounces of fluid per day and 32 ounces allowed for dietary. The oral intake and output record revealed oral fluid intakes from 05/06/12 through 05/16/12. Fluid intakes varied. During an interview on 05/23/12 at 1:50 p.m. the dietary manager reported only food intakes recorded by dietary staff and nursing for fluid intakes.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to document an appropriate diagnosis for a psychotropic medication for 1 of 17 (Resident #9). The facility reported a census of 59 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 4/26/12 documented diagnoses for Resident #9 including hypertension, depression, and a history of breast cancer. The MDS documented the resident had no issues with sleep and did not receive hypnotic medication during the MDS assessment window of seven days.

On 9/22/11 the resident started taking the hypnotic Restoril at bedtime.

On 1/12/12 the physician discontinued the Restoril and prescribed another hypnotic Dalmane every day at bedtime.

On 2/12/12 the physician changed the Dalmane to an as needed basis.

Review of the psychoactive medication monthly flow record for December 2011 noted behaviors of repeated requests and tearfulness. The record failed to document the resident's difficulty with sleep

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F 329	Continued From page 74 Review of the psychoactive medication monthly flow record for January 2012 noted behaviors of repeated requests and tearfulness. The record failed to document the resident's difficulty with sleep. Review of the psychoactive medication monthly flow record for February 2012 noted behaviors of repeated requests and tearfulness. The record failed to document the resident's difficulty with sleep Review of the psychoactive medication monthly flow record for March 2012 noted behaviors of repeated requests, tearfulness, and attempted to self transfer. The record failed to document the resident's difficulty with sleep. The clinical record failed to contain an appropriate diagnosis for the hypnotic medication. During an interview on 5/23/12 at 3:45 p.m. Staff I, licensed practical nurse, stated the medical record did not record a diagnosis for the hypnotic medication. Staff I notified the physician and obtained a diagnosis of insomnia for the hypnotic use.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding

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the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, and staff interview, the facility failed to document influenza and pneumococcal education prior to administration for 13 of 15 residents reviewed (Resident #1, #3, #4, #5, #7, #8, #9, #10, #11, #12, #13, #14, #15). The facility reported a census of 59 residents.

Findings include:

The vaccines/immunizations policy stated each time the facility offers immunizations the facility will provide education regarding the benefits and potential side effects of the immunizations to the resident and their legal representative.

1. The Minimum Data Set (MDS) assessment dated 4/26/12 documented diagnoses for

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Resident #9 including hypertension, depression, and a history of breast cancer.

The informed consent for the influenza vaccination dated 10/25/10 gave the facility to administer the vaccination but did not document education given to the resident or responsibility party.

The clinical record lacked documentation of the administration of the pneumococcal vaccination.

2. The MDS assessment dated 4/5/12 documented Resident #10 had diagnoses including Alzheimer's disease, anxiety, and a psychotic disorder.

The informed consent for the influenza vaccination dated 1/3/09 gave the facility to administer the vaccination but did not document education given to the resident or responsibility party.

3. The MDS dated 5/3/12 documented Resident #11 had diagnoses including hypertension and peripheral vascular disease.

The resident admitted to the facility after the influenza season but the clinical record lacked documentation the resident received the vaccination.

4. The MDS dated 4/14/12 documented Resident #12 had diagnoses including hypertension and diabetes mellitus.

The informed consent for the influenza

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vaccination dated 9/21/09 gave the facility to administer the vaccination but did not document education given to the resident or responsibility party.

5. The MDS dated 3/16/12 documented Resident #13 had diagnoses including multiple sclerosis, and anxiety, and neurogenic bladder.

The informed consent for the influenza vaccination dated 8/7/02 gave the facility to administer the vaccination but did not document education given to the resident or responsibility party.

6. The MDS dated 4/26/12 documented Resident #14 had diagnoses including neurogenic bladder and multiple sclerosis.

The informed consent for the influenza vaccination dated 4/17/09 gave the facility to administer the vaccination but did not document education given to the resident or responsibility party.

The clinical record lacked documentation of the administration of the pneumococcal vaccination.

7. The MDS dated 3/4/12 documented Resident #15 had diagnoses including heart failure and diabetes mellitus.

The clinical record lacked documentation of the administration of the pneumococcal vaccination.

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During an interview on 5/17/12 at 9:04 a.m. Staff I, licensed practical nurse, stated the admitting nurse documented the residents influenza and pneumatically status. Staff I provided resident's consents to the vaccination but provided no documentation of education.

8. The Minimum Data Set (MDS) Assessment Tool dated 03/29/12 identified Resident #4 with diagnoses of Alzheimer's disease, diabetes mellitus, and anxiety disorder.

The informed consent for the influenza vaccination dated 09/22/11 gave the facility permission to administer the vaccination but did not document education given to the resident or responsibility party.

9. The Minimum Data Set (MDS) Assessment Tool dated 03/29/12 identified Resident #8 with diagnoses of Alzheimer's disease and depressive disorder.

The informed consent for the influenza vaccination dated 09/21/11 gave the facility permission to administer the vaccination but did not document education given to the resident or responsibility party.

10. The Minimum Data Set (MDS) Assessment Tool dated 02/10/12 identified Resident #5 with diagnoses of traumatic brain injury and seizure disorder.

The informed consent for the influenza vaccination dated 09/22/11 gave the facility

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F 334	Continued From page 80 permission to administer the vaccination but did not document education given to the resident or responsibility party. 11. The Minimum Data Set (MDS) Assessment Tool dated 03/09/12 identified Resident #1 with diagnoses of cerebral palsy and seizure disorder. The informed consent for the influenza vaccination dated 10/17/11 gave the facility permission to administer the vaccination but did not document education given to the resident or responsibility party. 12. The Minimum Data Set (MDS) Assessment Tool dated 04/05/12 identified Resident #3 with diagnoses of Alzheimer's disease and osteoporosis. The informed consent for the influenza vaccination dated 09/23/11 gave the facility permission to administer the vaccination but did not document education given to the resident or responsibility party. 13. The Minimum Data Set (MDS) Assessment Tool dated 03/23/12 identified Resident #7 with diagnoses of Alzheimer's disease, heart failure, and renal insufficiency. The informed consent for the influenza vaccination dated 09/28/11 gave the facility permission to administer the vaccination but did not document education given to the resident or responsibility party.	F 334		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced

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by:
Based on clinical record review, observation, facility policy review, and staff interview, the facility failed to follow infection control measures for 7 of 15 residents observed (Resident #1 #2, #8, #10, #13, #14 & #15). The facility reported a census of 59 residents.

Findings include:

Review of the facility's policies include:

I. The hand washing procedure dated 2009 lists when to wash hands:

Before and after assisting the resident with personal cares

Upon and after coming in contact with resident's intact skin

Before and after assisting the resident with toileting

After handling soiled items

After removing gloves

After completing duty

Before and after changing a dressing

After contact with a resident's mucous membranes and bodily fluids or excretions

II. The skills checklist regarding hand hygiene technique dated 7/07 listed the following

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instructions:

Wet hands

Apply soap

Hold hands lower that elbows

Lather and clean the nails

Perform hand hygiene using rotating, rubbing motion for 10-15 seconds

Wash at least two inches above the wrist

Dry hands thoroughly

III. The cleaning up spills of bloodbourne pathogens policy directs staff to use a paper towel to clean the area then disinfected with 10% bleach or other commercial chlorine or iodine based disinfectant. All clean up material should be placed in a biowaste disposable bag and then secured in a biohazard container.

IV. The initiation of isolation precautions (undated) policy directs the facility to complete the following:

Educate procedures and precautions to the resident and family

Inform staff the need for procedures that must be initiated and maintained

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Obtain a cart for supplies appropriate for the type of isolation

Obtain appropriate signage and post outside the door

Notify other departments the resident required isolation.

1. During observation on 5/16/12 at 11:05 Resident #15 used the arm bicycle then used the pulleys used by Resident #10. Staff failed to cleanse the pulleys between residents.

During observation on 5/16/12 at 11:00 a.m. Resident #10 used the pulleys, hand cones, and arm bicycle. staff failed to sanitize the arm bicycle between residents.

Resident #13 used the pulleys and the range of motion arch after Resident #10. Staff did not sanitize the equipment between residents.

2. During observation on 5/16/12 at 11:38 a.m. Staff U, licensed practical nurse, removed the split gauze and cleansed around Resident #14 suprapubic catheter site with soap and water. Staff U then removed the split gauze around the gastronomy tube site and cleansed the area without changing gloves between the two areas.

3. During an interview on 5/16/12 at 4:25 a.m. Staff FF, licensed practical nurse, stated housekeeping kept material used to clean blood spills in the housekeeping closet. Review of the

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housekeeping closet revealed no cleaning supplies for cleaning blood spills. Staff FF attempted to look through the policy and procedure manual but could not locate the manual.

During an interview on 5/22/12 at 2:03 p.m. Staff Q, housekeeper, and Staff M, housekeeping supervisor, stated the facility used the hospital germicidal for cleaning blood spills. Examination of the bottle indicated the germicidal could be used for blood spills. During the interview, the surveyor question on isolation precautions. Staff M had no knowledge of any resident in isolation and had no knowledge of how to clean a resident's room in contact isolation for Clostridium Difficile. Staff M reported she would call the product distributor to ask about products that eliminated the Clostridium Difficile toxin.

During an interview on 5/23/12 at 4:00 p.m. Staff M spoke with the product distributor and they informed her to use bleach to clean contact isolation rooms for Clostridium Difficile.

6. The Minimum Data Set (MDS) Assessment Tool dated 03/09/12 identified Resident #1 with diagnoses of cerebral palsy and a seizure disorder. The MDS identified the resident required total dependence of two staff for toileting, bed mobility, and transfers. The MDS identified the resident with impairment of functional limitation in range of motion for both side of the lower extremities (hip, knee, ankle, foot).

Observation on 05/16/2012 at 8:04 a.m. revealed Staff G and Staff AA, Certified Nursing Assistants, assist Resident #1 with incontinence

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care. Staff G and Staff AA both washed hands and applied gloves to their hands. Staff G walked across the room and picked up the trash can with her right gloved hand and then provided incontinence care to Resident #1 with no change of gloves.

7. The Minimum Data Set (MDS) Assessment Tool dated 05/10/2012 identified Resident #2 with diagnoses of coronary artery disease, hypertension, end stage renal disease, chronic obstructive pulmonary disease. The MDS identified the resident received dialysis treatment.

A hospital history and physical dated 04/20/12 identified Resident #2 with a recent admission for pneumonia and was on a ventilator for several days in another hospital and treated with antibiotics at the first of this month. Over the past two weeks since discharge, he/she reported having increasing diarrhea. A stool sample verified the resident with an infection of the bowel (Clostridium difficile - a contagious infection) and was started on Flagyl 500 milligrams intravenously every 8 hours and Vancomycin 125 milligrams by mouth four times a day (antibiotics).

Facility admission orders dated 05/03/12 directed staff to administer Vancomycin (antibiotic) 250 milligrams by mouth every six hours for ten days and check stool sample for C-diff times one.

The medical record revealed a stool sample collected on 05/04/12 with no final results until upon request by the surveyor on 05/16/12. The facility failed to obtain test results in a timely manner or implement infection control practices until a confirmed negative result was obtained.

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Observations during the initial facility tour on 05/14/12 and throughout the survey revealed no isolation precautions or identification of type of isolation of Resident #2's room.

During an interview on 05/16/12 at 1:50 p.m. Staff F and Staff AA, Certified Nursing Aides, reported no knowledge of any type of isolation precautions or infection for Resident #2.

Review of the monthly infection control logs from 12/2011 through 05/2012 revealed incomplete/tracking methods. The monthly logs revealed the name of the resident, type of antibiotic administered, and type of infection (such as upper respiratory, urinary tract, or eye infection). The log lacked information if a culture was obtain, organism, isolated or nosocomial infection. The infection control log lacked tracking methods to determine if infections were related to certain areas of the facility, staff, or contaminated items.

8. An observation made on 5/16/12 at 5:50 a.m. revealed Staff C, CNA, donned gloves without first washing her hands to provide incontinent cares for Resident #8. Staff C placed some dark blue colored washcloths at the side and then wet them with water from the room sink. Staff C set 2 plastic bags at the foot of the resident's bed and checked the resident's incontinent brief and verified it to be wet. Staff C turned off the sink faucet with a gloved hand, applied body wash cleansing lotion to the washcloth, set the washcloth down on the bedding beside the left siderail, picked it up and began cleansing the

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right groin, inner labia using a clean corner of the washcloth for each wipe. Staff C took a clean wet washcloth and cleansed the left hip, left buttock, turned the cloth to a clean corner, cleansed the peri-rectal area, right upper thigh washing back and forth using the same area of the washcloth for all areas cleansed. Staff C removed the incontinent brief, and then removed her gloves. Staff C donned clean gloves, turned on the water faucet with a gloved hand, and wet another washcloth and applied body wash solution, and turned off the water with a gloved hand. Staff C cleansed the peri-rectal area again, rolled the resident onto the left hip, washed the right hip back and forth using the same area of the washcloth. Staff C removed her gloves, donned a clean pair of gloves, and rolled the resident onto the right hip. Staff C applied the clean incontinent brief, removed her gloves, and secured the brief in place. Staff C positioned the resident onto the right side with a body pillow up against the resident's left side, floated the heels on a small pillow, and covered the resident with a blanket.

At 6:35 a.m. Staff E, CNA, donned gloves and left the resident room to obtain the Hoyer Lift. Staff E brought the lift into the room and continued to wear the same pair of gloves. Staff E began removing the resident's bedding. Staff D, CNA, donned gloves. Neither CNA washed their hands upon entry to the resident room and before donning the gloves. Staff D and Staff E connected the Hoyer sling to the lift. After the CNA's transferred the resident into the recliner chair, Staff D removed her gloves and proceeded to explain to the surveyor she should have washed her hands before starting the transfer

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and should have washed her hands upon leaving the resident's room earlier. Staff D dressed the resident. Staff D attempted to lean the resident forward to secure the bra and stated she really needed to get another staff member to assist her due to the resident leaning so far forward. Staff D covered the resident with a blanket and left the room to seek help. Staff F, CNA entered the room and did not wash her hands prior to assisting with the resident. A clean incontinent brief fell to the floor, Staff D picked it up and placed it on the bedside table. Staff F left the resident room after assisting with dressing without washing her hands. Staff D just finished instructing Staff F to wash her hands before leaving the room just a few minutes prior to this. Staff D washed her hands, turned off the water faucet with a paper towel and then proceeded to dry hands with this same paper towel. Staff D rewashed her hands, turned off the faucet handle with a bare hand and prepared to provide oral cares to the resident. Staff D stated she needed to leave the room to retrieve more plastic bags. Staff D placed the incontinent brief from the floor, on the overbed table, and moved it to the resident's wheelchair seat. Staff D removed gloves and washed hands prior to leaving the room. Staff D returned to the resident room, donned gloves without washing hands, and completed oral cares.

F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	F 492	

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in

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F 492	Continued From page 90 such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide access to the policy and procedure manual to all employees. The facility reported a census of 59 residents. Findings include: 1. During observation on 5/16/12 at 4:25 a.m. Staff FF, licensed practical nurse, attempted to locate the policy and procedure manual behind the nurse's station but could not locate the manual. During an interview on 5/23/12 at 10:10 a.m. Staff I, licensed practical nurse, stated she kept the policy and procedure manual in a locked cabinet in her office. Staff I stated if an employee needed the policy and procedure manual, they would need to ask Staff I for the manual.	F 492		
F 501 SS=D	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on quality assurance meeting	F 501		

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F 501	Continued From page 91 documentation and medical director interview, the facility failed to include the medical director in the creation and implementation of facility policies and procedures. Findings include: 1. According to the quality assurance attendance records, the medical director attended meetings on 6/2/11, 9/6/11, 12/6/11, and 3/6/12. During an interview on 6/1/12 at 9:48 a.m. the medical director stated she did not assist the facility with the policies and procedures. The medical director stated the facility held a quality assurance meeting on 5/24/12 after the survey team informed the facility of concerns areas. The medical director stated the facility did not communicate the concerns and did not ask for her input in correcting the concerns. The medical director had no knowledge of the state operation manual or the regulation that stipulates the duties of the medical director.	F 501		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		

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This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and staff interviews failed to provide complete documentation of the resident's participation in activities to ensure consideration of each resident activity interests. Concern noted for seven residents, #9, #11, #12, #15, #3, #5, and #7. The facility identified a census of 59 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 4/26/12 documented diagnoses for Resident #9 including hypertension and depression. The MDS documented the resident required extensive assistance for transfers and walking in the hallway. The resident has a Brief Interview for Mental Status (BIMS) score of 11 with some difficulty with recall.

The care plan dated 5/9/12 listed a goal that the resident will participate in activities of interest such as games, good old days and church. The care plan failed to list a resident specific goal such as determine how many times would he/she like to plan to participate in the activities he/she enjoys during a determined time frame.

An activity assessment dated 5/18/12 documented the resident participated in six or more activities a week.

The Daily Record of Resident Participation for March 2012 documented the resident attended

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activities, however the documentation consisted only of a code of 1=active participation, or 2= passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended. The documentation did not reveal information to show the resident attended or participated in games, good old days, and church.

The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

2. The MDS dated 5/3/12 documented Resident #11 had diagnoses including hypertension and peripheral vascular disease. The MDS documented the resident required extensive assistance for transfers and did not ambulate.

The activity assessment dated 5/15/12 documented the resident participated in three to five activities a week.

The care plan dated 5/16/12 did not list interventions for activity participation and did not list a resident specific goal.

The Daily Record of Resident Participation for March 2012 documented the resident attended activities, however the documentation consisted only of a code of 1=active participation, or 2=

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passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended.

The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

3. The MDS dated 4/14/12 documented Resident #12 had diagnoses including hypertension and diabetes mellitus. The MDS documented the resident as independent with transfers and walking.

The activity assessment documented the resident attended activities of choice.

The care plan dated 4/25/12 instructed staff to remind the resident of activities. The care plan failed to list a resident specific goal.

The Daily Record of Resident Participation for March 2012 documented the resident attended activities, however the documentation consisted only of a code of 1=active participation, or 2= passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended.

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The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

4. The MDS dated 3/4/12 documented Resident #15 had diagnoses including heart failure and diabetes mellitus. The MDS documented the resident required extensive assistance for cares and did not ambulate.

The activity assessment documented the resident attended six or more activities a week.

The care plan dated 3/14/12 documented a goal to express satisfaction with the quantity and quality of socialization. The care plan did not include a resident centered goal.

The Daily Record of Resident Participation for March 2012 documented the resident attended activities, however the documentation consisted only of a code of 1=active participation, or 2= passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended.

The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

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The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

Observation on 5/16/12 at 9:33 a.m. revealed activity staff conducted a group activity. The resident sat in the wheelchair in the room.

During an interview on 5/22/12 at 1:40 p.m. Staff L, activity director, stated sensory stimulation consists of music, reading, and applying lotion and done on a one to one basis. Staff L stated she did one to ones twice weekly but failed to document the activity provided.

During an interview on 5/23/12 at 1:13 p.m. Staff L stated she had activity director education but had training in care plans. Staff L stated she did not have knowledge that the resident needed a resident centered goal and to document the specific activity the resident attended.

5. The Minimum Data Set (MDS) Assessment Tool dated 04/05/2012 identified Resident #3 with diagnoses of Alzheimer's disease and osteoporosis.

The care plan dated 07/06/11 through 07/17/12 identified the resident needed help to activities as he/she enjoyed music and church. The goal revealed the resident will participate in music and church program. The approach listed staff to place resident in the lobby for church and music activities and his/her spouse comes to visit everyday. The care plan and activity program documentation failed to identify specific frequency

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of activity attendance and what activity he/she participated.

6. The Minimum Data Set (MDS) Assessment Tool dated 02/10/2012 identified Resident #5 with diagnoses of traumatic brain injury and seizure disorder.

The care plan dated 04/17/2008 through 05/22/2012 identified Resident #5 interest him/her such as music programs and afternoon delight. The approach documented staff to invite the resident to group and assist as needed to attend activity. The care plan lacked documentation for Resident #5 specific protocol with identified approaches.

The Daily Record of Resident Participation for March 2012 documented the resident attended activities, however the documentation consisted only of a code of 1=active participation, or 2= passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended. A review of the documentation did not reveal participation in music, and afternoon delight.

The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

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7. The Minimum Data Set (MDS) Assessment Tool dated 03/23/12 identified Resident #7 with diagnoses of Alzheimer's disease, renal insufficiency, heart failure, and paraplegia.

The care plan dated 11/15/2006 through 07/03/2012 identified the resident needed lots of encouragement and assistance to attend and participate in activities. The goal documented the resident will attend and participate in the activities that interest him/her (bingo and church).

The Daily Record of Resident Participation for March 2012 documented the resident attended activities, however the documentation consisted only of a code of 1=active participation, or 2= passive participation; with the names of ten facility residents on each page. There was no information detail on what activity the resident attended. A review of the activity documentation did not reveal Bingo and church participation.

The Daily Record of Resident Participation for April 2012 documented the resident attended activities but failed to identify which activities the resident attended.

The Daily Record of Resident Participation for May 2012 documented the resident attended activities but failed to identify which activities the resident attended.

F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	F 518	

The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing

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	165257	A. BUILDING _____ B. WING _____	06/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

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staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview; the facility failed to ensure the staff knew the facility's policy and procedures for diaster preparedness. The facility identified a census of 59 residents.

Findings included:

1. During the Environmental task for the annual survey, the staff interviewed did not know the facility's procedure when asked; specifically related to missing resident, fire, and tornado.

Staff HH, Housekeeping staff, interviewed on 5/23/12 at 2:55 P.M. stated she had employed at the facility for 6 1/2 years. When asked about what to do if a resident was missing she stated she would report it to the Charge Nurse and look for the resident. When asked about fire she stated get resident out of room find the fire, get resident out, and help. She stated she couldn't remember. When asked about a tornado she stated close the windows, take residents to a safe area like bathroom, shower rooms. Then stated "I can't remember, I do it when we are going through it."

Staff II, Dietary staff, interviewed on 5/23/12 at 3:05 P.M., stated she would ask a Charge Nurse or go to the Disaster Preparedness book when asked about a missing resident. When asked about a fire she stated she would look in the Disaster Preparedness book. When asked what

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she could remember about what she should do she stated shut kitchen door, shut off lights, get a fire extinguisher, go to Charge Nurse, get the location of the fire, go down that hall and help evacuate if necessary. For tornado she stated to listen to the Charge Nurse for information. For a warning she stated to shut windows, pull curtains, give extra blankets, get residents away from windows and cover them or get them into the hallway.

Staff JJ, Certified Nurse Aide, interviewed on 5/23/12 at 3:30 P.M., stated for a missing resident she would go to the Charge Nurse, do a head count, find out who is missing and look for the resident. If the resident was not found, notify the Charge Nurse who would notify the Administrator and Director of Nursing. For a fire she stated find and pull fire alarm, if resident is in room, take resident out; make sure the door is closed, remove the residents on either side of the room the fire is in, tell the charge Nurse who calls the Fire Department. For a tornado, a watch-pull the drapes and get resident away from the window, if resident has oxygen find a safe plug in. If residents are in the rooms wait for an all clear. For a warning she stated Charge Nurse tells precautions, close drapes, cover residents with extra blankets and pillows, evacuate from windows.

Staff R, Licensed Practical Nurse and Charge Nurse, interviewed on 5/23/12 at 3:50 P.M. stated for a missing resident she would call out the code over the phone to alert staff, alert Administrator and DON, do a room to room search and outdoors then if not found alert the police and the

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missing resident's family.

For a fire-she stated there was a new Administrator with a manual, she would call over the intercom, put someone down the hall and send someone with a fire extinguisher call Administrator, pull fire alarm and the Fire Department would be notified.

For a tornado the police radio alerts the facility of changes. For a warning or watch. Ensure the safety of the residents, family and Administrator and DON are aware, close the windows, provide blankets for extra padding in room. Can move residents to safe areas such as Medication Rooms or shower rooms.

A review of policies for these disaster situations are:
Tornado Procedure:
Watch:
1. Any person hearing a weather announcement should notify his/her supervisor immediately.
2. Monitor weather radio and turn on local TV station that gives up to the minute weather information.
3. Communicate severe weather/tornado watch information throughout the facility. communicate any changes in weather conditions as quickly as possible.
4. Close all windows, drapes and fire doors.
5. check that all treatment carts and first aid kits are stocked and flashlights and battery operated radios are in place.
6. All residents/tenants should be accounted for and asked to remain inside. vision and/or hearing impaired resident/tenants and visitors should be identified and staff should be prepared to assist

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them if conditions deteriorate.
7. (same as Step 6)
8. Be prepared to switch residents/tenants on oxygen and other life sustaining equipment to portable means if it becomes necessary.
9. Notify the administrator and all department heads of the watch and steps taken.

Waring:
1. Monitor weather radio and turn on a local TV channel and assign someone to monitor.
2. Provide pillows and blankets as necessary to residents/tenants and visitors.
3. Move residents/tenants to resident rooms, bathrooms and/or the inside wall of their room away from windows.
4. Communicate weather changes as necessary.
5. stay in close communication with local emergency agencies.
6. switch residents/tenants on oxygen and other life sustaining equipment to portable means.
7. Move resident/tenants' chats and the medical/treatment books to the medication rooms if feasible.

Fire Procedure:
If a fire occurs, stay calm and take the following steps as quickly as possible:
1. Rescue anyone in immediate danger. if possible, pull the nearest fire alarm.
2. activate the fire alarm and call 911 to alert law enforcement officials and the fire department.
3. Confine the fire by closing all doors and windows near the fire.
4. Turn off ventilation systems and remove oxygen form the fore area.
5. Extinguish the fire if it is not life threatening or if you feel confident of extinguishment. otherwise, leave it to the professionals.

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6. If it is safe to do so, the person discovering the fire should remain in the fore area to maintain control of the area, all other employees should report to the nurses's station.
7. Charge nurse will delegate the following tasks:
a. Evacuate residents in immediate danger area and relocate to nearby safe location.
b. Implement evacuation plan if necessary.
Additionally:
The following steps should be taken while waiting for the fire department to arrive:
1. move all residents/tenants and visitor away from the immediate fire area to the other side of the doors. Place residents/tenants and visitor in rooms and close doors. Give adequate attention to those who are vision and hearing impaired. Be firm with everyone--move them by whatever means possible. Be sure to account for everyone.
2. close all doors to every room in the affected area.
3. Turn off all air conditioners/ventilation systems
4. Meet the firefighters at the door and direct them to the fire.
5. keep all unauthorized people out of the building.
6. if resident chats or medical/treatment records are in danger, move them to a secure area (i.e. medication room, locked storeroom, locked vehicle, etc.)
7. When the is extinguished and the fore chief instructs you to do so, give an "all clear" announcement over the intercom. DO NOT return to the building until the fore department gives the all-clear.
8. Notify appropriate staff members.

Elopement (Missing Resident)

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When a suspected elopement has occurred the following steps will be initiated:
The charge nurse will notify the entire staff by announcing by overhead page that "Dr. Wander return to room_____." (The room number announced would be the resident's room number who is missing." Repeat the page three times to alert staff that an elopement is suspected.

1. All employees must assemble quickly after hearing this page at nurse's station 2 for instructions from the charge nurse.
2. The charge nurse at station two(2) will inspect the alarm panel to make sure all switches ore in the "ON" position.
3. Each employee will quickly search their respective areas. This would include closets, bathrooms, or any area that a resident might be able to get in and report a head count for their areas.
4. The charge nurse will send on CNA to physically check each exit door to determine that alarms are working properly.
5. The charge nurse will send two (2) CNAs outside to search the immediate perimeter of the building and grounds. They will report back to the charge nurse immediately there after.
6. If the resident is not located during this initial search, the chafe nurse will call both the Administrator and the Director of Nursing.
7. The Administrator or the Director of Nursing will notify the authorities, and give a physical description as well as a recent photo if available.
8. The charge nurse will notify the immediate family/responsible party/guardian of the resident being missing. the charge nurse will also notify the attending physician.
9. Search parties will be designated to search

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F 518	Continued From page 105 surrounding areas and streets. They are to be available by cell phone, and are to report in every 20 minutes. 10. The Director of Nursing will notify the local emergency room, and local merchants to be aware if the missing resident should be observed in the area. The facility presented an in-service on Disaster Preparedness to staff including Staff HH, II, and JJ on 4/10 and 12, 2012. The in-service included a quiz that the staff completed. All three staff completed the quiz for the in-service.	F 518		

GOLDEN AGE SKILLED
NURSING AND REHAB
CENTERVILLE, IOWA 52544
FC#4823

2567 PLAN OF
CORRECTION

The preparation of the following plan of correction for these deficiencies does not constitute, and should not be interpreted as an admission or an agreement by the facility of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction was executed solely because provisions of state and federal law require it. This plan of carrection serves as our statement of substantial compliance with all rules and regulations.

F156

Staff training has been completed and an audit system, monitored by the Administrator/designee when each notice is given, has been put into place to ensure that the resident's rights to request a standard review claim appeal or expedited claim appeal (done within 72 hours) for financial liability is accurately completed.

Follow up to the education provided to the social service director ruled that the employee's performance did not meet the facility's expectation.

The social service director was terminated on July 12, 2012. Administrator named as social worker designee. Quality assurance will review.

F157

Nurses have been informed of protocol/process for notification of physicians and family for this resident (Resident 5) and all other facility residents. A Hot Chart system has been implemented, which will identify each Chart with concerns, the charts will in turn be audited by the DON/designee. QA will review.

F246

A facility expectation was put into place, prior to the 5/14/2012 survey, which requires no routine medications/treatments to be administered prior to 6 a.m. unless otherwise ordered by the physician or requested by resident. Random audits will be performed quarterly by the DON or her designee.

Staff C na longer warks far the facility, and DON or designee will continue to educate and audit randomly on proper care techniques. QA will review.

F248

Discussion held with activity director on regarding the

importance of following the regulation requirement which denotes the need for ensuring the activities offered to residents establish a resident centered activity goal on the care plan for residents 1,4,6,8,10,14, and will review assessments for 1:1/provide to all other 1:1 residents- resident specific goal(s) on care plans by 7/31/2012. All other resident activity assessments and care plans will be reviewed and audited on an ongoing basis as quarterly care plan conferences are held or as needed.

Audits to the Activity Care Plans resident-centered goals by MDS coordinator/designee as MDS are completed. QA will review.

F252

A checklist has been put into place which will audit the safety/appearance of resident equipment for replacement. For Resident 6 a new wheelchair with new harness and straps was ordered.

The equipment will be inspected by the Restorative Department periodically. Progress will be reported at safety committee meeting.

QA will review.

F279

The facility Social Service staff has been informed with respect to the regulation that outlines the need for the facility to review and revise resident's plan of care to include specifics relative to a resident's psychosocial needs. She has also been informed on the importance of the need of addressing a resident's psychosocial needs with the resident and documenting actions and interventions. The facility has hired a new MDS coordinator. She has received training and will be receiving on-going training with respect to the need of creating and updating plans of care and to care plan specifics with goals and interventions such as chronic health issues and special needs.

Specific to resident 1, the plan of care has been updated and the Direct Care staff has been trained. These approaches have been added to the resident's care plan.

Resident 2 no longer resides in the facility.

A protocol specific to Resident 5 (Seizure Protocol) was received from his health care provider and is a part of his plan of care and individual resident chart.

Specific to Resident 9 per social service notes on 5/1/2012, resident explained that she wasn't happy with her

roommate and is just ready to die. She feels she is old and ready to go. However, is not going to harm herself. Her plans are to stay in the nursing home. Resident has since then had a room change and is enjoying activities and seems content.

DON/designee and/or nurse consultant will randomly review the Plans of Care and MDS on an ongoing basis.

Follow up to the education provided to the social service director ruled that the employee's performance did not meet the facility's expectation. The social service director was terminated on July 12, 2012. Administrator named as social worker designee.

QA will review.

F281

Professional standards regarding medication administration are now being practiced for 5 of 15 residents. For Residents 4, 11 and other residents in facility the same prafessional standards are being practiced.

Resident 25 and 2 no longer reside in the facility.

Discharge orders for residents are being addressed with use of discharge instruction form and continued educatian to licensed staff.

Clarification of orders are being addressed with education and enforcement of higher standards of practice by DON/ADON.

Licensed staff meetings have been and will continue to be held for education and monitoring of nursing practices. This is being monitored by the DON and ADON. In order to assure this practice is permanent; the plan to monitor the performance will also be through review with a quarterly quality assurance process and review of system by consultant nurse on her visits.

F282

Direct care staff have been re-educated as to the purpose of a Care Plan and the reason care plan must be used to provide cares. CNAs will be audited by the DON/Designee or Charge Nurses randomly on an on - going basis.

CNAs will be included in the weekly Care Conferences for which they provide cares when able.

Family was contacted on Resident 13 and adjustment to care plan was made.

Physical therapist screen completed and order has been received to evaluate splints on Resident 14.

Care plan reviewed and updated on Resident 15.

Glasses were ordered and received for Resident 4.

QA will review.

F309

Assessments and interventions and education for incontinent care of Resident 1 has been put into place.

Bowel management interventions have been put into place for Resident 8 and care plan reviewed and updated.

Pain management assessment has been put into place for Resident 3 and core plan has been reviewed and updated.

Resident 16 no longer resides in the facility.

Education on assessments and interventions to provide care services for highest well-being have been given to the licensed staff.

DON and ADON continue to reinforce high standards of nursing practice with education on assessments, critical thinking and care issues identified in this tag.

In order to ensure the standard of care remains high, performance will also be

reviewed and discussed at the quarterly QA meeting.

The consultant nurse will review the system and do audits of hot charting and assessment skills of the nurses and make needed recommendations on her visits. Medical Director has agreed to provide involvement in approval of pain assessment and bowel protocol.

F312

Resident 16 no longer resides in the facility. Random audits will be completed regarding the facility expectations that residents will receive two bathing procedures per week unless otherwise care planned.

Staff C is no longer employed by the facility.

QA will review.

F 314

Resident 2 was discharged from facility.

To address this, an outside source was contacted and will be educating staff in July. Education and consultation will be offered in the future as needed.

Weekly skin sheets are being documented and monitored by skin RN nurse. DON and ADON are monitoring the system.

To further ensure that Golden Age is providing interventions to prevent skin breakdown, the practices and overall program on skin will be reviewed at our quarterly QA meeting and Medical Director will be asked for her guidance.

The nurse consultant will continue to randomly review the skin care process on her visits.

F318

Facility is providing range of motion exercises for 5 of 16 residents with Residents 4, 10, 13, 14 and 16 identified.

In addition the current restorative program has been reviewed and revised by the physical therapist. All restorative staff have been reeducated and the restorative nurse is monitoring and supervising the program.

Periodic review of program for effectiveness will be on going. DON/MDS Nurse will monitor.

To further ensure that the facility is meeting the intent of the F tag (to prevent decrease in ROM), the restorative program will be reviewed quarterly at QA meetings and revised if and when necessary. The consultant nurse will also review F tag periodically.

F323

The water heater for the designated Hall is located in a room. A lock was installed on May 25, 2012, on the door and only maintenance and Administration will have a key and be able to make adjustments to the water temps. An audit was put into place to monitor the temperatures at various times by the maintenance and housekeeping departments. Any temperatures outside the required range will be communicated to the Administrator.

At the time of the survey there was a call light in the room named in F 323 however, it was strung from the opposite side of the room. Maintenance installed a call light for the second side for the room occupied by Resident 10. Housekeepers will be responsible to randomly audit resident rooms for missing/broken call lights.

All future resident electric wheelchair usage will follow the policy established which will include safety assessment by Occupational and/or Physical Therapists. Resident 15 is no longer using an electric wheelchair.

Resident 13 was screened by physical therapy to determine independence in room.

QA will review.

F325

Snacks are being delivered and offered per regulation and dietician recommendations. Weight loss is no longer a problem for Resident 15. Doctor is now monitoring for weight gain; if more than 5 pound weight gain, notify doctor.

The Dietary Manager and ADON will monitor snack charting.

QA will review.

F327
Staff have been made aware of the importance of offering fluids to Residents 1, 6, and 7. Resident 2 no longer resides in the facility. Nursing staff were reminded of the importance of offering fluids to residents. Audits are being done by the ADON. Concerns will be brought to QA.

There is no resident presently on fluid restriction at Golden Age. If a fluid restriction resident would be admitted staff will follow a system for tracking fluids and an effort for consistent tracking methods will be initiated. ADON and dietary staff will work together on this to ensure that this will be provided. It will also be reviewed at QA.

F329

The appropriate diagnosis for an identified medication for Resident 9 was obtained during the survey.

Medical records are being reviewed for completeness of diagnasis with medication orders on all new admissions. The ADON will monitor this process.

To ensure that the facility will continue with the system to have diagnosis with medications ordered on all new admissions this F tag issue will be reviewed through the QA process. The process will include getting diagnosis for all medications on quarterly care plan assessment.

F334

The facility has provided and documented influenza and pneumococcal education for the 13 identified residents under this F tag.

A form with educational information for influenza and pneumococcal vaccines is being implemented and will be used for vaccines going forward.

Education for all residents receiving vaccines this fall will be part of the facility program as required by F tag 334.

ADON will monitor this to ensure compliance. This F tag

will be reviewed ot QA meetings.

F441

An infection control progrom has been revised ond now oddresses oll areos cited under tog F441 for 7 of 15 residents. Hondouts ond ongoing educotion on hond woshing, hond hygiene, blood spills ond isolotion have been provided to stoff.

Monitoring ond oudits on dressing chonges, glove use ond knowing clean ond dirty technique hove been reinforced. Incontinent core is being oudited and stoff ore being held responsible to know dirty ond cleon concept, hond woshing ond glove use during cores.

Cleoning equipment in theropy in between residents use is port of progrom.

Audits ond reinforcement of educotion will continue on infection control ot nursing meetings throughout the yeor.

DON/ADON ond restorotive nurse will be responsible to monitor. In oddition the consultant nurse will monitor this rondomly on her visits.

Trocking infections ond identifying sources/cultures when oble ond mopping for trends is now port of the infection control program. Our infection control report will continue to be reviewed ot the

quarterly QA meeting in efforts to stay in compliance with F tag 441.

F492

Golden Age has provided a nursing policy manual for the nursing department.

The nursing policy and procedure manual is available at the nurse's station.

Updates for the policy manual will be done by consulting nursing company and reviewed with medical director.

To provide access to all employees this F tag 492 will be discussed at quarterly QA meeting and Medical Director will have access to review and make recommendations as needed.

F501

Golden Age has a Medical Director who has agreed to be responsible for implementation of resident care policies and coordination of medical care in the facility.

The Medical Director has been open to participate in the QA process and has received the outline of F tags received during the recent annual survey.

The administrator and DON/ADON will continue to provide information to the Medical Director on the

regulations that stipulate the duties of the Medical Director.

This F tag will be reviewed as part of the QA program and the Medical Director's recommendations will be implemented when provided.

Medical Director will review the policy and procedure manual annually and make any recommendations.

F514

Activity Coordinator has been informed of the importance to complete documentation of the resident's participation in activities to ensure consideration of each resident's activity interest. Residents 9, 11, 12, 15, 3, 5 and 7 completed by 7/6/12. All other residents requiring 1:1 will be reviewed and updated by 7/31/2012. The administrator will oversee the process and concerns will be brought to QA.

F518

Unannounced staff drills on all three emergency procedures will be part of periodic review of procedures and educational endeavors.

Education has been reinforced to staff with a disaster preparedness hand out concerning tornado, fire and

elopement. Educational endeavor will be continued periodically.

Random interviews will be completed on emergency preparedness policies by the administrator for the next 6 months.

QA will review.

PRINTED: 06/27/2012
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

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L1093	58.12(1)l Admission, transfer, and discharge 58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. l. For all residents residing in a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A on July 1, 2003, and all others subsequently admitted, the facility shall collect and report information regarding the resident's eligibility or potential eligibility for benefits through the Federal Department of Veterans Affairs as requested by the Iowa commission on Veterans Affairs. The facility shall collect and report the information on forms and by the procedures prescribed by the Iowa commissions on veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services. In the event that a resident is unable to assist the facility in obtaining the information, the facility shall seek the requested information from the resident's family members or responsible party. For all new admissions, the facility shall collect and report the required information regarding the resident's eligibility or potential eligibility to the Iowa commission on veterans affairs within 30 days of the resident's admission. For residents residing in the facility as of July 1, 2003, and prior to May 5, 2004, the facility shall collect and report the required information regarding the resident' s eligibility or potential eligibility to the Iowa commission on veterans affairs within 90 days after May 5, 2004. If a resident is eligible for benefits through the federal Department of Affairs or other third-party payor, the facility shall seek reimbursement from such benefits to the maximum extent available before seeking reimbursement from the medical	L1093		

7-17-12 DW

DIVISION OF HEALTH FACILITIES STATE OF WA

Jenica Quandt — administrator — 7/12/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE

DEPARTMENT OF INSPECTIONS AND APPEALS

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE SKILLED NURSING & R	1915 SOUTH 18TH STREET CENTERVILLE, IA 52544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1093	Continued From page 1 assistance program established under Iowa Code chapter 249A. The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II,III) This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to assess the resident ' s veteran status and submit the information to the Veterans Affairs for assessment of benefits for 3 of 7 residents reviewed (Resident #23, #24, & #25). The facility reported a census of 59 residents. Findings include: 1. Resident #23 had an admission date of 9/28/11. The release form asked the question if the resident or spouse had veteran eligibility. The release form failed to have documentation whether the resident had veteran eligibility. 2. Resident #24 had an admission date of 1/4/12. The release form asked the question if the resident or spouse had veteran eligibility. The release form failed to have documentation whether the resident had veteran eligibility. 3. Resident #25 had an admission date of 6/21/11. The release form indicated the resident had military background. The current resident status for veteran eligibility did not include the resident. During an interview on 5/17/12 at 10:45 a.m. the Nurse Consultant confirmed the lack of information on veteran eligibility on Resident #23 and Resident #23. The Nurse Consultant confirmed the facility had not submitted Resident #25 ' s information to the Department of Veterans Affairs.	L1093		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0642	A. BUILDING _____ B. WING _____	06/06/2012

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L1093

The social services director was reminded of the importance of VA documentation. The data will be shown to the administrator with each new admission and administrator will then check online, if appropriate, to make sure it has been entered correctly.

The social service director was terminated on July 12, 2012. Administrator named as social worker designee.

QA will review.